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the requirements for the degree of
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THE ROLE OF JORDANIAN HOSPITAL NURSES IN PROMOTING
PATIENTS' HEALTH

NOORDEEN SHOQIRAT

**A thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Philosophy
(Nursing)**

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ABSTRACT

Background/Rationale: In recent years growing attention has been given to health and the development of health promotion within the hospital setting. This is in order to tackle the soaring medical costs and foster health improvement in the population. Given their unique relationship with patients, hospital nurses are urged to promote the patient's health, yet internationally, little is known about their role in health promotion and, specifically, no Jordanian study was found that examines such a role.

Purpose of the Study/ Setting: To understand the nature of nurses' roles in health promotion in a large teaching hospital in Jordan.

Study Design/Methods: An in-depth constructivist case study design using a multiple method triangulation strategy was used. The study involved four phases. The first phase examined nurses' role in health promotion using focus group discussions (n=8), non-participant observations and semi-structured questionnaires. The second phase focused on patients' understanding of health and health promotion using focus group discussions (n=8). The third phase examined health promotion from the perspective of hospital stakeholders and a nursing educator. The fourth phase included documentary review of nurses' job descriptions and nursing philosophy of care.

Data Analysis: Whilst quantitative data were analysed using SPSS, qualitative data were thematically analysed using N-Vivo (2) and filing and colour index method.

Findings: Generally, hospital nurses' views towards their role in health promotion were positive. However, their perceived role and actual practice of health promotion were largely restricted to individualised information giving and behavioural change approaches. The thesis identified diverse contributing factors to this situation. This includes lack of time, shortage of nursing staff, lack of knowledge in health promotion, power imbalance between doctors and nurses, low public image of nursing and gender issues related to nursing.

Conclusion: The way hospital nurses' role in health promotion is currently perceived and operationalised in practice is inconsistent with the recent health promotion ideas operating at the level of empowerment and political actions. Addressing the identified barriers therefore, together with a radical reform from curative services towards health promoting health agenda, is crucial. Unless this happens, hospital nurses' ability to promote health might continue to be questioned. The thesis develops a conceptual model illuminating Jordanian hospital nurses' role in health promotion together with contributing factors.

Keywords: hospital nurses, health, health promotion, empowerment, case study, methods triangulation and organisational reform.

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Chapter One: Introduction

1.1 Introduction

The concept of health has increasingly been the focus of the literature and widely linked to the nurses' role in health promotion, specific cultures and health service development (Jones, 1997, Helman, 2000, Pelikan et al, 2001, Catford, 2005, Mittelmark, 2007). It is argued that, in order to understand health promotion, having an idea of what to promote is vital (Ewles and Simnett, 2004, Hjelm et al, 2005). However, whilst nurses' understanding of health affects the development of their role in health promotion (Callaghan, 1999, Caelli et al, 2003), the way patients interpret health contributes to their receptivity to health promotion activities (Yoho and Ezeobele, 2002). Understanding such a link is the root of establishing effective health promotion strategies (Tones, 2001, Tones and Green, 2004).

Such strategies are a key principle to minimize the rapidly inflating medical cost, particularly within the hospital setting (Uddin, 2001). This is because many of the major causes of the morbidity and mortality worldwide are preventable and linked to individuals' lifestyles (e.g. circulatory diseases) (Phillips 2002). Given the fact that hospital nurses spend much of their time with patients, it is argued that they have a potential role in promoting patients' health (Whitehead, 1999, McDonald, 2000, Irvine, 2005, Cross, 2005, Casey, 2007, Whitehead et al, 2008).

Against this background however, the ability of hospital nurses to promote the health of patients has been questioned (Whitehead, 2002, 2003, Irvine, 2007). Their understanding and practice, of health promotion revolves exclusively around medically oriented health education activities as opposed to empowering health promotion (Cross, 2005, Casey, 2007). The delivery of health promotion is haphazard (Scriven 2003) and, in general, their role in promoting health is unknown (Hilgersson and Prohaska, 2003). Two decades ago, Lalonde (1989, p: 40), noted that hospital staff, such as nurses, have ignored the part they can play in health promotion and summed up their attitudes towards such a role as: "let somebody else do it, we already have too much to do". In view of health promotion development, the picture

about whether such a quotation reflects the reality of hospital nurses' attitudes today is vague. Although much has been achieved concerning health promotion within the community setting (Charlesworth, 2001, Clark, 2001, Alborz, et al 2002, Davidson and Machin, 2003, Hillemeier et al, 2003, Runciman et al 2006), there has been little attempt in nursing research to investigate nurses' practices and attitudes towards health promotion in the hospital. The existing studies, however, are often small-scale research, relying only on one method (McBride, 1994, Davis, 1995, Maidwell, 1996, Cross, 2005). Others are largely plagued by poor methods, particularly the lack of observation (Irvine, 2007, Whitehead et al, 2008) and thus the gap between theory and practice has not been empirically scrutinized.

Some studies which are widely quoted in the literature are now more than a decade old and have not yet been replicated to verify their findings (McBride, 1994, Davis 1995, Maidwell, 1996). What is striking however is that when hospital nurses' role in health is examined by research, the methodology is developed around behavioural change and individualistic interventions (McBride, 1994, 2004, Maidwell, 1996, Cross, 2005, Nawafleh et al , 2005, Irvine, 2007). By contrast, there is a lack of systematic research exposing the link between organizational culture and its impact on the development of hospital nurses' role in health promotion. To add to the problem, to date, none of the studies has examined both health promotion and health among hospital nurses and patients.

As the lack of nursing research in health promotion within the hospital settings is internationally evident, it is not surprising therefore that very little attention has been given to this area of research in low income countries. Although the health service has been dramatically developed in Jordan, hospitals in Jordan still aim to exclusively cure disease instead of promoting peoples' health (Nawafleh et al, 2005). The word "Hospital" itself in Jordan is often linked to the notion of illness and "bad news". However, promoting of healthy lifestyle initiatives have been emphasised by a number of Jordanian scholars (Haddad and Umlauf, 1998, Mhasneh, 2001, Haddad et al, 2004, Gharaibeh et al, 2005, Nawafleh et al, 2005). With the growing health challenges in Jordan such as the lack of financial resources and the escalating

number of refugees, particularly after the recent Iraqi War, hospital nurses' roles as health promoters have become vital. The review of the literature reveals that health and health promotion related issues in Jordan have not yet been investigated from the perspective of hospital nurses, patients and stakeholders (for example, ward supervisors). In light of the current empirical literature, little evidence is available to inform the development of hospital nurses' role in health promotion and to deliver culturally competent health promotion work matching patients' needs (McLennan, and Khavarpour 2004). Indeed, this situation poses dilemmas to nurse managers and educators on how to train hospital nurses to develop their role in health promotion in a complex setting where the scope and the impact of contributing factors to such a role are largely unknown.

Considering the paucity of research in this area, the current thesis therefore attempts to bridge this gap in the literature. Once the barriers, which might prevent nurses from putting their health-promoting duties in practice are identified, a future strategy to overcome them can be devised. By broadening the research baseline and including other populations from Jordan, it is hoped that the study offers a Middle Eastern health promotion contribution to this body of knowledge. The overall aim of this study was to understand the nature of hospital nurses' role in health promotion. To achieve this aim, a number of questions need to be answered. These include:

1. What is nurses' knowledge and understanding of the concept of health and health promotion?
- 2- What is patients' knowledge and understanding of the concept of health and health promotion.
- 3- What are nurses' and patients' attitudes and beliefs towards health promotion in hospitals.
- 4- What are nurses' and patients' perceptions of their experiences of health promoting activities?
- 5- What are the factors identified by the key hospital stakeholders (Training and development manager, surgical and medical wards supervisors and a nursing educator) which might affect the practice and the development of nurses' roles in health promotion.

1.2 Study Context: Jordan, Health Care System and Nursing Education

Jordan is a low-income country, which is located in an important geographic and political position in the Middle East (see figure 1). The population of Jordan is about 4.5 million and life expectancy is 71 years for men and 75 years for women (Petro-Nustas, 2002). About 92% of the population is literate (Orbach and Delaney, 2004). An extended family system dominates the Jordanian culture. In this type of family structure, the elderly are highly respected and all family members support each other at all times.

Diabetes, hypertension and breast cancer are major health problems in Jordan which are often linked to environmental pollution and unhealthy lifestyle practices (Petro-Nustas, 2002, Gharaibeh et al , 2005). The economic recession following the recent Iraqi War has affected Jordanian's health. In recent years, it is estimated that about 700,000 Iraqi refugees have already fled to Jordan while thousands of Palestinian refugees remain (Byman and Pollack, 2006). This influx is important in a small country like Jordan, with limited resources. More generally, the incoming refugees have contributed to lowering standards of living and increasing poverty as well as significant increases in the prices of food and housing. Also it contributes to increased demand on the health care system in general.

However, the health care system in Jordan is one of the more efficient in the region in delivering high standards of care (Oweis and Abushaikh, 2004). It includes public hospitals (n=27), military hospitals (n=10), private hospitals (n=56) and large teaching hospitals (n=2) (Mrayyan, 2005). The public sector provides the majority of the population with health care at low costs. There are also many primary health care centres in Jordan which offer basic care and screening such as dealing with minor injuries.

The current study was undertaken in one of the two big teaching hospitals in Amman (see Figure 2). It was considered as a suitable setting for the study given its size and the management support of the research in general. Indeed, the hospital offers care

for diverse patients. This includes public and private patients and some refugees from Palestine and Iraq. Thus, nurses in this hospital deal with different population groups, which are of interest to this study given its cultural focus and its case study design. Nursing education in Jordan involves two programs. The bachelor degree (four years) and the Diploma degree (three years). However, in 1998 the diploma degree was phased out and now a BSN degree is the only educational route to entry to the nursing at a professional level. Those with the diploma degree need to complete a short course in nursing to attain the BSN.

Currently there are eight public and private universities that offer the BSN degree. The education is coordinated by the Nursing Council and the Jordanian Centre For Nursing. The latter is responsible for the development of the profession in general and includes many PhD holders from Jordan. Many nursing programs especially at the post-graduate level are coordinated with international universities from the US, UK and Australia.

However, nursing curricula in Jordan are largely influenced by the American and British model of nursing (Shurique et al, 2007). For example, the concept of health promotion, caring, ethical nursing, autonomy, accountability, creativity, nursing process and life long learning are integrated in the overall nursing curriculum in Jordan (Petro-Nustas et al, 2001).

More recently, Jordanian nurses are urged to adapt health promotion principles and models in practice taking into account their effectiveness and cultural suitability in hospitals and primary health care centres (Haddad et al, 2004, Gharaibeh et al, 2005, Nawafleh et al, 2005). Yet, as explained in this thesis, the extent to which this has occurred in practice has not yet fully been examined in quantitative and qualitative terms.

Although nursing education among Jordanian universities is not identical, it is similar. This due to the fact that curricula are developed by highly qualified nurse educators who are in frequent contact and -cooperation with the Nursing Council, as

well as Jordanian High Education Ministry. Therefore, all nursing students in Jordan study similarly curriculum and undertake their placement at the same clinical areas, such as: public; private; and military hospitals.

Figure (1): The Map of Jordan

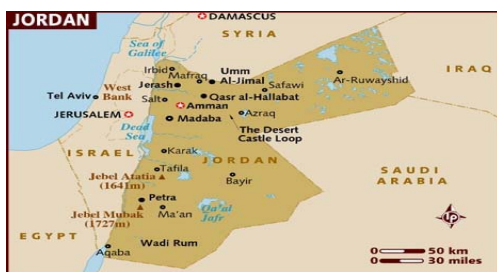


Figure (2) The Teaching Hospital



1.3 The Structure of the Thesis

This thesis falls into 12 chapters. Whilst chapter one has presented the introduction and the study's context, chapter two examines the theoretical development of the concept of health. Models of health (e.g. social and medical) are outlined and debated. The cultural construction of health in relation to nursing practice and the health care system are examined. The chapter reveals a lack of empirical literature on the meaning of health from the perspective of both hospital nurses and patients.

In Chapter Three the concept of health promotion and its theoretical development are investigated. Relevant health promotion theories are compared and contrasted. The empowerment model, its features and limitations are debated. Health promoting hospitals movement together with the implication for hospital nurses' practice are highlighted. Studies on health promotion to date are critically examined.

Chapter Four sheds light on the methodology and methods used in this thesis to achieve its aims. The utilisation of both quantitative and qualitative approaches in this study are examined. The relevance and associated problems of methods triangulation strategy are highlighted. The case study design and its implications for the research together with possible limitations are pointed out. The relevance of each

method (e.g. observation) and possible problems are examined. A detailed account of data analysis procedures, relevant problems and trustworthiness of data are given.

Chapter Five: This chapter reports the demographic data of participants. The response rate of the questionnaire and non-response related problems are sketched.

Chapter Six: This chapter aims to present findings pertinent to the conceptions of health held by participants. Whilst the first part of this chapter deals with the way hospital nurses understand health, the second part addresses patients' own images of health and related needs.

Chapter Seven: This chapter presents findings concerning hospital nurses' attitudes towards their role in health promotion in general. Their understanding of health promotion together with related experiences are highlighted. Following this, patients' understanding of health promotion as well as related experiences is highlighted. The nature of hospital nurses' roles in health promotion from the perspective of ward supervisors, the nursing educator and the manager of training and development is examined

Chapter Eight: Findings surrounding the development of nurses' practices in health promotion are explored in this chapter. It sheds light on what nurses do in the name of health promotion as well as those contributing factors affecting the practice

Chapter Nine: In this chapter the extent to which hospital is a suitable setting for health promotion is examined from different sets of data. Findings are analysed within the context of current debate in this area.

Chapter Ten: Findings that affect hospital nurses' roles in health promotion are systematically reported in this chapter. They were categorised into 2 groups. The first one deals with factors within the ward level. The second deals with those factors at the level of organisation and community.

Chapter Eleven discusses and debates major findings that have emerged from this work within the national and international theoretical and empirical literature. Implications for nurses' practice, education and future research are sketched. The developed conceptual model about hospital nurses' role in health promotion is presented. This is followed by Chapter Twelve which concludes the whole thesis in relation to its aims

1.4 The search of the literature

The materials relevant to the study focus and its questions were located from different sources. An on line search was carried out to locate papers on the concept of nursing, health and health promotion as well as related issues such as well-being. The search used a range of health related literature databases, in particular those, which have a nursing focus. These included Medline, CINAHL, PUBMED, British Nursing Index and World Health Organisation database. A manual search in the reference lists of the gathered literature was also used. Google Scholar search engine was also used together with the British library catalogue for the PhD theses. Recent books in health related issues have been located and reviewed. Finally, some references were located as a result of communication with other researchers and PhD students in the area of health promotion and nursing. Whilst articles written in English were selected, a few relevant Arabic articles were also translated and included.

The initial search focused on the period between 1986 and 2006 and then it has been updated during the writing up stage of the thesis to include literature from 2006 and 2008. This period of time (1986-2008) was considered as suitable for the aim of the study because the health promotion setting movement gained momentum in the mid 1980's by the Ottawa charter as explored in the thesis. Indeed, the development of hospital nurses' role in health promotion was monitored over the last two decades. However, literature about classic related theories and models has been included (e.g. Maslow model).

Faced with the huge bulk of health promotion literature, the search was narrowed down using the funnel structure procedure to address the study questions and focus. Initially, in the searching process, the concept “health” was used in general and then later in combination with the use of related concepts, themes and sub themes. This included, health and culture, health and gender and spirituality, health and theories and models, health and health care system, health and nursing, health and middle east / Mediterranean area and Jordan, health and hospital and nurses’ related attitudes and knowledge in general.

Likewise, when it comes to health promotion the search started by focusing on the concept of health promotion and then narrowed down to focus on the study questions through using a mixture of two or three concepts. This included health promotion and health education, disease prevention, health promotion and health policy, health promotion models and theories, health promoting hospital movement, health promotion and Jordan and nursing. Hospital nurses’ role in health promotion, their attitudes and practice internationally were examined and then specifically highlighted within the Jordanian context with reference to health in general, nursing, education and health promotion curriculum.

Chapter Two: An Investigation of the Meaning of Health, Nursing and Related Studies

2.1 Introduction

The growth of interest and activity in health promotion has been accompanied by many attempts to examine the nature of health concept in particular cultures. It is argued (Pender, 1996, Katz et al, 2002, Tones and Green, 2004) that health promoters such as hospital nurses are unlikely to improve health and to bring about change unless they have adequate understanding of the meaning of health and its determinants. Thus, if people's health is to be promoted effectively, the concept of health needs to be explored culturally. To this end, there is a need to establish a theoretical background about the meaning of health itself before any attempt to examine health promotion related issues.

This chapter aims to analyse the concept of health in different cultures as well as its determinants. It examines the medical, social and cultural constructions of health. Then, the relevant empirical work about the concept of health is investigated and the need for the current research is identified. This chapter therefore serves as a theoretical backdrop against which the emanating results from the current study are analysed.

2.2 Health Concept: Meaning and Development

When health related literature is reviewed it becomes obvious that the concept of health is still one of the most frequently reported concepts. Health has not only been associated with people's health behaviour (Paxston et al, 1994, Ogden et al, 2002, Hjelm et al, 2005) but also with the population's mortality, morbidity, life satisfaction, happiness, health policy, sexual health, education and economy (Buchanan, 2000, Davey et al 2000, Helman, 2000, McPake, et al, 2002).

The concept of health however is contested and has diverse and sometimes conflicting meanings that are both socially and culturally constructed. The concept of health was derived from the old English word "hoelth" which means being safe,

sound and whole (Pender, 1996,). Historically, physical wholeness was of major importance for acceptance in social groups. Physical power and nature were frequently linked together. Those people suffering from disease or malformation were ostracised from society. The reason was not only because of the fear of contagion from physically obvious disease but also according to Blaxter (2001) there was repulsion at grotesque appearances. In light of this, it is not unexpected that the review of literature found that being healthy was constructed as natural in a certain environment or in harmony whereas unhealthy was constructed as unnatural or contrary to nature (Davey et al, 2001).

Whilst it is acknowledged that this view of health stigmatised those suffering from physical or mental health, it has some focus on the link between people's health in relation to the environment. Such a link is still frequently reported in recent writings (e.g. Bunton and Macdonald, 2002, Katz et al, 2002) but with a more holistic meaning of environment, which includes, for example, pollution and security. It appears therefore that health, with its connections with the environmental factors such as natural disasters, had been recognised as long time ago, but due to the advanced research in health and social sciences (Tones, 2001), such factors are no longer treated separately when it comes to the meaning of health.

However, in order to follow a certain framework of "good health", the review of the literature indicates that in the eighteenth century there were significant calls for having a standardised definition of health. As with the case in modern literature (Seedhouse, 2004, Bowling , 2005), the need for agreement about the meaning of health was a subject of interest. Several societies (e.g. Arabic, Chinese, Western and European cultures) did attempt to find a unified concept of health in order to establish effective interventions that could promote a high level of health (Jones, 1997). Reviewing the classical attempts in defining the meaning of health is too extensive to explore here but the most famous assertion is provided. For instance, the Western world had attempted to find a unifying concept of health in the Greek idea of a proper balance between body and mind. Based on this, health cannot be achieved unless such a balance occurs. This idea also has been found more recently

in Hispanic cultures (Yoho and Ezeobele, 2002) as well as among Arab men in Sweden (Hjelm et al, 2005). This could mean that the Greek idea of health has transformed over time in different cultures from one generation to another and perhaps is still dominant. However, regardless of its popularity and origin, the state of balance between body and mind is a narrow view of health but the notion of *balance* is common. It would not be possible to reach a status of balance between the body and mind unless other factors are considered such as the environment. Indeed, the idea of balance between body and mind is not possible to be converted into reality. For example, philosophers and creative scientists are rarely found among Olympic laureates (Davey et al (2001). The classical debate about the meaning of health in different societies has continued in eighteenth and mid-nineteenth centuries but, like the Greek view of health, there were unrealistic definitions and a lack of universal agreement.

2.2.1 WHO's Definition of Health

As a result of the significant failure of classical definitions of health (see above), the WHO in 1946 proposed the well-known definition, which was considered as a standard definition for health. Health was defined by the WHO (1946) as:

“ The state of complete physical, mental, and social wellbeing’ and not only the absence of disease and infirmity”.

This definition has proved to be robust and it is frequently cited in the literature in particular within nursing and health promotion contexts, and it would be worth reviewing its effectiveness and applicability. The definition was revolutionary as it consists of three aspects of health including physical, mental and social well-being. It has many advantages, which were recognised by many authors (Bunton and Macdonald, 2002, Katz et al, 2002, Lee and Newberg, 2005). This is not surprising as it is postulated (Pender, 1996, Bowling 2005) that the WHO's definition reflects concern for the individual as a total person rather than the sum of parts. In addition, the definition places health within the environmental context rather than a disease

focus. Recently, health promotion authors go further to contend that the WHO's definition is well acknowledged in the literature not only because its positive reference to well-being but also it is useful to be adapted at a political level centring on equity and empowerment and asserting that health is a standard of living (Tones and Tilford, 2001, Tones and Green, 2004). Although they did not offer obvious guidance about how to incorporate these ideas into practice, their suggestions might demonstrate that the WHO's definition of health can be used as a framework for promoting health at both the individual and political level. Medical writers, on the other hand, advocate to lesser extent that the WHO's definition can be deemed as a milestone to distinguish between positive health such as well-being and negative aspects of health which exclusive emphasis on disease prevention (Downie et al, 1991). On this basis, the WHO's definition made a significant addition to the literature by arguing that health is beyond the disease-linked issues and it is rooted in the individuals' social life.

However, whilst the above arguments are encouraging to adopt the WHO's definition in health care and perhaps in health promotion areas, it suffers from serious flaws. It has been criticised on different grounds. This could be due to the extensive research in health promotion, which needs an effective understanding of the meaning of health capturing different health related factors. As it will be elaborated in the next chapter health promotion needs to be rooted in a clear context of the meaning of health. It would appear however that the WHO's conceptualisation of health is a far way from framing such a context.

The WHO's definition is totally unrealistic and too idealistic. This is because it assumes that someone somewhere can achieve a 100% state of health. This implies a misunderstanding of the meaning of health as a complex qualitative experience shaped by an individuals' context (Katz et al, 2001). It could also lead to a central confusion about the meaning of "complete" or "incomplete health". For example, is the health of a person with a physical disability complete or incomplete? To add to the problem, the definition is based on the assumption that people's views of "the state of health" are alike. Such an assumption has been discredited by

considerable evidence. Earlier studies have shown that people define the state of health in many different ways such as fitness, energy, sexual activity and even wealth (Young, 1996, Davey, 2001, Davey et al, 2001, Hjelm et al, 2005). In light of this, the state of health is linked with many other views of health that are not included in the WHO's definition.

Likewise, Ewles and Simnett (2004) expressed their concerns about the quality of the WHO's conceptualisation of health which implies a static position whereas life and living are anything but static. This indicates a misunderstanding of the fact that health in its holistic facets (e.g. physical, mental, spiritual) is in a state of continuous change. Young (1996) acknowledges the advantages of the WHO's definition but she points out other problems as below:

“..... Such a wide ranging definition can sometimes make it difficult to determine things which are not covered by the heading “health concern”...could we, for example, consider a woman experiencing relationship difficulties with her husband and family “unhealthy”? (p:242).

As indicated above it seems that the too broad a definition of health makes it difficult to specifically address the needed health interventions to achieve the desired outcomes. This raises significant concerns, which could lead to misinterpretations among health care providers themselves.

A further weakness of the WHO's definition of health stems from the possibility of linking its meaning with health promotion. Whilst it could be used as a framework for health promotion (Tones and Green, 2004), adopting the WHO's definition as a guideline for promoting people's health might produce not only ineffective health promotion activities but also unrealistic expected outcomes such as a “100% complete health status”. Thus, health care providers, and in particular nurses, need to acknowledge that the aims of maintaining health should be within realistic boundaries and reasonable expectations. Taking the above gaps in definition together, it is not surprising that Seedhouse (2004) goes so far as to argue that the

definition from the literature should be removed from the literature. However, this argument can be challenged. The WHO's definition is still stimulating further discussions about the meaning of health and thus could generate a more valid understanding the concept of health. Indeed, in contradiction to Seedhouse's recommendations, other authors (Naidoo and Wills, 1998, Tones and Tilford, 2001) postulate that the WHO's definition of health has opened different channels for research in health care despite its limitations. Subsequently whilst its limitations are recognised, the WHO definition could be considered as a springboard for conceptual development of both health and health promotion.

From the review of the models and theories of health, it is evident that they are some conceptualisations generated by the WHO's definition. In order to avoid a lengthy discussion of diverse definitions of health which is a foundation for hospital nurses' role in health promotion (Tones and Green, 2004), a brief thematic analysis was undertaken. Doing so is recommended in order to capture key themes when vast theoretical literature is available about a specific concept (Gillis and Jackson, 2002). Accordingly, the major definitions of health were located and categorised. Each definition was inductively divided into its central dimensions. Then, the definitions were compared in relation to each other and repeated themes were identified. Although in the different conceptualisations, it was found that "adaptation" and "actualisation" underlay the meaning many of the health definitions.

2.2.2 Health as Adaptation

Adaptation-based definitions of health are derived primarily from the physiological concept of homeostasis. The literature found that one of these theories that clearly reflects such a status is Dubos's (1965) theory which was called "adapting man". The theory advocates the stability and defined health as a state or condition that enables the individual to adapt to the environment. Whilst it is not obvious if there are stages involved during the adaptation, in the context of this theory, it can be suggested that unless the individual has the capability to adjust to the environmental stressors (e.g. poverty), health cannot be experienced.

As people's ability to adapt is different in response to certain environmental conditions, it seems that an adapting theory resonates the idea that health is "relative" rather than an absolute concept (Bowling, 2005). Dubos himself considers that the optimum health is a mirage because man in the real world should face the physical and social forces that are forever changing, are frequently unpredictable and are often dangerous. That is, the nearest approach to the meaning of health according to the above theory and that health is a state of a specific level of physical and mental health that allows individuals to function successfully with the environment.

Likewise, a number of nursing theorists have proposed definitions of health, concentrating on adaptation but different terms were used such as "balance" and "harmony". Some conceptual development was made. For example, Johnson (1980) argues that health is a balance among different behavioural systems. These include attachment, dependency, sexuality, aggression and achievement. Other writers (King, 1990, Tones and Tilford, 2001, Ewles and Simnett, 2004) propose that if health is to fit different contexts, it needs to be seen as an ability to adapt continually to changing demands, expectations and stimuli. The value of the above arguments lies in the fact that health is seen as a dynamic state. Health therefore could be defined holistically relating to the way in which individuals deal with stressors while functioning within their own cultures.

Developing this argument further, it can be argued that the failure to cope with either internal, external or both types of stimuli is "unhealthy". This indicates that in the adaptation status, health needs are met, more energy is gained and no, or very few, stressors exist that could enhance the ability to make a promoting health decision. On this basis, health cannot be achieved unless individuals have the energy to adjust to the environmental, cultural and social challenges. Keeping this in mind, nurses need to identify the stressors that could prevent patients from gaining energy because of an unstable health status resulting from unsuccessful adaptation. That is, adaptation is a cornerstone when health is to be identified. It means not only to adjust to the external environment but significantly to internal stressors (e.g. having a disability) that could

affect self-esteem and confidence. However, there is a serious flaw to exclusively focusing on health from the adaptation perspective. This stems from the fact that adaptation is often linked with normality (Blaxter, 2001). Debatably, normative definitions of health based on adaptation predict, “what could be” based on “what is” leaving little room for incorporating growth and evolutionary emergence into definition of health (Neuman, 1995, Seedhouse, 2004). The second theme identified in this inductive analysis offers perhaps a more coherent picture about health.

2.2.3 Health as Actualisation

Whilst adaptation based definitions of health, informed by the ability to adapt to stressors, health from the point of view of actualisation is more expansively focusing on human potential. One of those found strongly advocating health as actualisation is Dunn (1990), Dunn hypothesises that actualisation is integrated in human function which is oriented towards maximising the potential of which the individual is capable. To this end, Dunn (1990) argues that three components are needed. This involves progression towards a higher potential of functioning, an open-ended challenge to live at a fuller potential and maturation of the individuals at higher level through the life cycle. Although Dunn (1990) makes no explicit reference to the individual’s context, Tones and Green (2004) argue that that high level of actualisation can only emerge in a both favourable and challenging environment. This demonstrates that health within the framework of actualisation incorporates not only achieving a high level of health during the entire life span but it also dynamically interacts with the constantly changing environment.

Likewise, Pender (1996) together with Ewles and Simnett (2003), postulate that health as actualisation involves the ongoing integration of mind, body and environment. In the same context, Orem’s (1995) self-care theory of nursing suggests that health is a state characterised by contentment towards fulfilment of one’s self ideal. Continuing personalisation therefore is the first step towards maturation and continuing development of self-care competency (Katz et al, 2002). That is, individuals cannot reach the state of actualisation unless they have an internal

awareness about their health which motivates them to achieve their own identified objectives.

The picture about health as actualisation is incomplete unless its fundamental principles are acknowledged. For example, the Maslow's self actualisation model (1976) highlights the fact there is no self-actualisation if the basic needs are not met (e.g. food, housing). That is, whilst health as adaptation and actualisation are presented separately here, they are closely interconnected. It would not be possible for individuals to achieve their potential if no adjustments were made to the surrounding conditions. That is, adaptation is prerequisite for self-actualisation.

2.2.4 Summary of The Meaning of Health

Based on previous sections (see above), it seems that health is a multidimensional concept and indeed it can only be understood from the inner world of people (Katz et al, 2002, Hjelm et al, 2005). Empirically the fact that health is a subjective concept delineated differently by people has been verified by trans-cultural research. It was found that their views of health ranges from having friendships, wealth and functioning at home to maintaining a good link with God (Paxton et al, 1994, Yoho and Ezeobele, 2002, Carroll et al, 2007). Consequently, it is argued (Pender, 1996, Seedhouse, 2004) that the increasing attempts to define health as "unfruitful exercise". It appears then that the endeavours to illuminate the meaning of health are an endless task. Thus, there is a need to examine health within a particular community, which might aid the delivery of culturally based health care (Katz et al, 2002). Nonetheless, the concept of health should not be given all the attention as little is known about its link with health promotion in practice (Yoho and Ezeobele, 2002, Tones and Green, 2004). In line with this argument it was proposed earlier by Kemm and Close (1995) that:

"There is a danger that obsessive concern with the meaning of health can paralyse our [health promotion] activity and create sectarian divides between workers who should be cooperating"(p: 23).

Whilst it is widely agreed that understanding the meaning of health is vital to guide health care development, too many attempts to define health could lead to disagreement about what should be promoted. Therefore, on the one hand, a clear understanding of health is central within the context of health promotion and nursing but on the other hand, there is an urgent need to ensure that the available definitions of health serve as a guideline for health promotion rather than a barrier for a collaborative work.

Against this backdrop however, today's literature continues to provide us with plenty of health definitions with different labels, ideologies that, according to scholars, fail to be utilised in practice and could not be consistent with lay people's understanding of health (Katze et al, 2002, Tones and Green, 2004). What is needed therefore is not only to define health as a concept, but also to explore how its meaning is constructed in a specific context (McLennan and Khavarpour, 2004). For that reason, the discussion will now turn to explore specifically the meaning of health from medical and social models. Their ideologies, implications as well as weaknesses, can be considered as a stepping-stone to understand health promotion with special reference to nursing.

2.3 Medical Model View of Health

It is evident that the medical view of health is the eldest among other models such as the social (Pender, 1996) and interestingly it is still dominant (Bowling, 2005). However, the phrases "medical model", "disease model" "preventive model" and "biomedical model" are used interchangeably in the literature and there is no agreement about the differences between them in viewing health. Thus, firstly, to avoid terminology confusion, the term "medical model" will be used throughout this thesis. Adequate exploration of the medical model in this chapter is fundamental given the fact that nursing research has shown that nurses' care plans as well as health promotion activities are aligned with this model (Cross, 2005, Irvine, 2007, Casey, 2007). Although it can be traced to the nineteenth century, the medical model

view of health remains the leading one and has been linked to different concepts. It is associated with “the state of the absence of diseases”, “treating sick people and providing specialised medical care” and “disease prevention” (Katz et al 2002, Seedhouse, 2004, Ewles and Simnett, 2004). Although there are different descriptions, they have the same focus on individuals’ pathological status-related issues. Laverack, (2004) proposes that the main principle of the medical model is treating the body as a machine that needed to be fixed. This focus was essential in eighteenth and mid-nineteenth centuries for example in curing epidemic diseases such as polio (Pender, 1996).

Yet Bowling (2005) found that in health care, where clinical interventions are specific and invasive, most existing indicators about health are reflected in the medical model. These indicators are concerned about signs and symptoms and the state of freedom from disease, which have been the long-standing focus of medical care. In light of this, it can be argued that the main epistemology (the link between the knower and what is known) of the medical model of health is for health professionals like hospital nurses to diagnose the disease and then to provide the medical treatment needed. In this scenario little attention is given to the contributing factors to health such as socio-economic status of individuals.

However, people can feel ill because of feeling pain and discomfort, not because of diagnosable disease. As reported by Davey et al, (2001) illness can be the result of pathological abnormality, but not necessarily so. They outlined the fact that someone may feel ill without a diagnosed disease such as vomiting due to too much drink, whereas someone may have a disease without any illness manifestations such as a presymptomatic cancer. Thus, the objection to the medical model is a narrow view of health concentrating merely on two major issues “disease and “treatment”. Many questions could challenge this flawed view of health. For instance, are people who do not suffer from any disease enjoying their life? Similarly, it is proposed that some people might have a life threatening illness but they still view their life as healthy because, for example, extensive social and emotional support being offered to them(Davey et al, 2001). Likewise, symptoms and mortality and morbidity rates are no

longer enough to evaluate a population's health due to the complexity of life today (Pender, 1996, Blaxter, 2001). This suggests that it would be a vital mistake to assume that people free of disease indicate a healthy population, whilst ignoring other aspects of health, such as social health. Whilst it is acknowledged that the medical model is an effective strategy to study ill populations (Bowling, and Windsor, 2001), it is unable to capture factors significant to health status such as people's socio-economic status (Patrick, 2003, Tones and Tilford, 2001).

Indeed, viewing health from the medical model could provide little about the population's health as a whole due to its extensive concentration on illness. Thus, only the bare minimum of visible suffering is addressed and the broader issues of health are more likely to be neglected. For instance, in Western populations the average percentage of ill people who require frequent medical treatment ranges between 15 and 25% (Bowling, 2005). This means that, if health is exclusively viewed in a medical way, it would not be possible to examine the rest of population's health (75%-85%). Although these percentages might not be applicable to other societies, they illuminate the limited scope of medical model in viewing health.

Further, it was found that using the medical view of health as a framework for changing people's unhealthy lifestyle resulted in low compliance (Clark, 1998, Musil, 1998). There is therefore a danger from linking the medical model of health with the possibility of enhancing people's overall health status. Nevertheless, it was surprising to find not only nurses aligning their interventions with its principle (Whithead, 2002, Casey, 2007) but also the physiotherapists (Ewles and Simmnett, 2003). Whilst its flaws are recognised, the question is why the medical model view of health is widely used in health related sciences? The reason, although evidence is limited, could be explained by the fact that nursing and physiotherapy had tried to follow medicinal principles in order to gain some legitimacy (Katz et al, 2002) and perhaps to achieve a high level of social respect (Seedhouse, 2004). Taking the above points together, it seems that patients' care plans and perhaps health promotion activities are grounded in the view of preventing illness-related issues as opposed to positive health, as explored in the next section.

2.4. Positive Health

Over the last decade there has been much emphasis on “positive health”. This perhaps due to the widespread recognition about the serious weakness inherent in the medical model view of health. Scholars (Tones and Tilford, 2001, Laverack , 2004) argue that positive health can be seen as an alternative to the medical model view of health, which has a disease focus. By contrast, positive health includes a wide range of issues such as building strength, enhancing resources and fostering resilience to enhance prospects for effective living (Tones and Green, 2004).

Ironically these are the key facets of efficient health promotion as discussed in the next chapter. At present it is essential to point out here that it was found that health promotion would be more effective when underpinned by positive indicators of health such as happiness (McBride, 1995, Hjelm et al, 2005). This explains Bowling’s (2005) postulation that health professionals as well as lay people need to view health more positively and not link it with illness. On this basis, health should be deemed as an integrated concept in the daily life of people regardless of the presence or absence of illness.

Nevertheless, again, like the concept of health itself, to date there is lack of agreement over the definition of positive health. Thus, it would not be possible to determine if lay people’s interpretations of health are positive due to the lack of a standard reference. The only clear criterion in the literature to distinguish between positive and negative health is that positive health means “good things” such as joy and happiness whereas negative health focuses on disease and medical treatment. That is, positive health is the ability to cope with stressful situations, the maintenance of strong social support, life satisfaction and an even level of physical fitness (Katz et al, 2002, Chaves et al, 2005, Bowling, 2005). In congruence with the above discussion, in recent years positive health has often described as an expression of well-being. These concepts are gaining significance and usefulness in social science, health promotion and public health (Bunton and Macdonald, 2002, Tones and Green, 2004). This might explain the new movement of defining health from the well-being

perspective. Both concepts of health and well-being are relevant to health promotion (Pender, 1996, Seedhouse, 2004) and thus well-being is given some attention in this review.

2.5 Well-being and Health

By reviewing some recent publications about health and health promotion, it becomes clear that well-being is a central concept in health promotion. As a result of dissatisfaction about the clear meaning of health, significant arguments were found advocating the concept of well being. Buchanan, (2000) argued that “well-being” is more suitable to use than health as it implies a positive meaning such as life satisfaction and happiness. This argument has been taken forward by Chaves et al, (2005) who claim that well-being offers considerable potential for unifying diverse sectors and interests around the goal of improving health and thus health promotion and health research (Chaves, et al, 2005). The former authors examined the meaning of well-being within a range of disciplines such as psychology, economics, health studies, society anthropology and biomedicine (Chaves, et al, 2005). Although the review’s comprehensiveness is constrained by excluding nursing literature, the results were that most disciplines tended to be biased towards one or two aspects of physical, social and psychological well-being with the main exception being child well-being studies. It was noted that economics made a significant contribution to the element of well-being in linking the affect of the economy on people’s well-being. On the other hand, psychology and biomedicine were more concerned about disease related issues in a well-being context. Chaves et al, (2005) argue further that understanding of the concept of well-being could have significant implications for structuring an improved meaning of health and therefore health promotion. Although there is little consensus about the meaning of well-being, Bowling (2005) supports Chaves et al’s, (2005) suggestion but she warns that well-being should not be seen as the absence of physical problems or psychological morbidity such as depression. This warning is not new and has been cited elsewhere in the nursing literature (Pender, 1996). What Bowling has argued is that well-being includes dimensions of self-esteem and sense of coherence.

These dimensions have been explored in depth elsewhere and it is not possible to cover their debate in this section (Bowling 2005). The important point to address is that the previous components of well being are subjective experiences; for instance, people's happiness and satisfaction cannot be entirely understood unless they are asked about their feelings. This argument has been adequately explored in the work of Tones and Tilford (2001) which focused on the development of health and well being in relation to health promotion.

They argue that the concepts of health as well as the concept of well-being are subjective experiences defined by people's "hedonistic feelings". That is, it is not possible to understand the meaning of health and related issues such as health promotion unless they are examined from the people own perspective. However, whilst well-being and health are often used interchangeably and are closely related, Buchanan, (2000) stressed that it is important to distinguish between them. For example, physical fitness does not necessarily imply a high level of well-being. He writes that:

"well-being is resulted through living well [and] through engaging in social practices that embody the values we wish to bring to being"(P:49).

Chaves et al, (2005) came to an interesting conclusion which stresses that well-being could be used from now on as an alternative to the concept of health. These commentators of well-being concept justified this "replacement" by considering other changes that happened to similar concepts. For example, Chaves et al (2005) point out that the terminology surrounding health education has changed to health promotion over the past decade. Thus, in their opinion, it might be possible that the concept of health could be replaced by well-being. Whilst it is acknowledged that well-being has a positive meaning of health, adhering to the Chaves et al's suggestion at the present time is risky.

As indicated earlier in this review, the meaning of health has been underdeveloped for a long time and, despite this, it is still a heated subject of debate. The concept of well-being on the other hand has not yet been fully examined in other disciplines

with special reference to nursing, explicitly, due to the lack of sufficient theoretical and empirical debate about the meaning of well-being.

It seems therefore, that it is too early to consider well-being as an alternative concept to health. In fact, shifting the concept of health to well-being could lead to further confusion rather than clarity about other concepts. If, for example, health promotion has changed to “well-being promotion” and health education to “well-being education”. In light of this, throughout this thesis therefore the term of health will be used.

In conclusion, , the ideology of health from the medical perspective is “negative” and is no longer acceptable because of its failure to capture broader factors that affect people’s health such as environmental and socio-economic. Nurses’ role in health promotion therefore might be limited as a result of the extensive use of the medical view of health. This might explain the dominance of the medically informed health education ideas in nurses’ role in health promotion (Furber, 2000, Cross, 2005, Casey, 2007). This is to be fully examined in the next chapter.

With the reported flaws associated with the medical model view of health in mind, the literature now moves on to examine the meaning of health from the social perspective. Doing so is driven by evidence indicating that the meaning of health is rooted in people’s social norms (Tones and Green, 2004, Laverack, 2004) and its meaning would remain vague without a sound understanding of its social construction.

2.6 Social Model View of Health

Significant numbers of nursing and social studies (Neuman, 1995, Paxton et al, 1995, Yoho and Ezeobele, 2002) found that the meaning of health is rooted in people’s social life. More specifically, Katz et al, (2002) address the characteristics of the social model of health by asserting that social health in specific cultures is exemplified by individuals’ interpersonal interactions such as visits with friends and

social participation, such as membership in clubs. Likewise, Tones and Green, (2004) propose further that the view of social model of health focuses on the main aspects of individuals' independency and interpersonal relationships. It is worth noting that these aspects interact with other dimensions of health from psychology such as the sense of continued growth (Schmutte and Ryff 1997).

From the nursing standpoint, both Pender (1996) and Neuman (1995) have tended to specifically conceptualise social health in relation to health promotion by focusing on the individual's functional ability to act as a member of the community. It is not surprising therefore that people's values of health need to be understood in the existing social and environmental status (Seedhouse, 2004).

A good example to elucidate the importance of lay people's views concerning health issues is provided by Katz et al, (2002). The writers argue that scientific terms take years to confirm the adverse impact of damp housing on people's health whereas ordinary people living in poor housing had a very detailed understanding of the impact of housing on their families, for example on childhood asthma. Based on the social model of health and the previous example, health promoters like nurses need to respond to people's expressed concerns of health related issues as well as their expectations rather than predominantly relying on medical assessment and scientific measures.

In comparison to the medical model discussed earlier, the social model appears to provide a more accommodating framework for people's health needs (see above). However, like the medical model view of health but to a lesser extent, viewing health from the social model poses some problems. The social health model is too concerned about social system breakdown, which is comparable to the medical model's focus on biological causes and malfunction (Tones, 2001). This might indicate that health within the social context has a narrow meaning, focusing only on social structures that might frame people's health beliefs as well as behaviours. Unlike the medical model, no attention was given by the social model to the individual's genetically determined and physical capability to interact with the

surrounding environment. This is essential as physical health is needed, for example to visit friends and to join clubs.

In other words, it can be argued that the strengths of the social model view of health are the weakness of medical model view of health and vice versa. Although they are different in features, both models suffer from drawbacks and thus health care providers need to acknowledge their failure in drawing a coherent picture about the meaning of health. In fact whilst

“ In the medical model the pathogens are viruses, or malfunctioning. In the social model they are poor housing, poverty [and] unemployment. The discourse may be different but the epistemology [the ways of knowing about knowledge] is the same. The social model’s [view of health] is not an alternative to the discredited medical model. It is a partner in crime” (Kelly and Charlton , 1995,p.82)

On the basis of the above arguments, both models tend to see health from an isolated angle either socially or medically. There is therefore a danger to integrate solely medical and social ideas of health in the framework of care and with special reference to health promotion. In summary, the social model of health could be used by nurses as a guideline to understand the relationship between people’s views of health in a specific community. It carries with it a clear commitment to social and perhaps political change focussing on social factors (Tones and Green, 2004).

It shares, however, a key criticism with the medical model as both of them have a limited focus on viewing health. Perhaps the social model of health has a wider, but not holistic view of health than the medical model as it pays some attention to individual’s social status. The weakness of the medical and social models of health has resulted in an attempt to draw together a more coherent meaning of health from a combination of disciplines as elaborated in the following section.

2.7 Biopsychosocial Model of Health

In the following sections, different aspects of health are addressed by health models, for example, physical and social. Such a categorisation has been a subject of debate. It is argued that the identification of different aspects of health could be useful in increasing the awareness of the complexity of the concept of health (Ewles and Simnett, 2003). In addition, it could be vital to deliver specific and effective care that targets certain aspects of health (Katz et al, 2002). However, nursing authors (Pender, 1996, Neuman, 1995) with the support from psychology (Kelly and Charlton, 1995) as well as health promotion (Tones Green, 2004), stressed that there is a need to adapt the biopsychosocial model of health in order to offer a multidisciplinary approach to health by taking into account many elements such as physical and mental. The model appears to sum up diverse disciplines in one model to capture as much as possible different facets of health.

In view of the current increasing criticisms of viewing health from one perspective such as sociology, adopting the biopsychosocial model by health professionals like hospital nurses is perhaps a step forward to perceive health more holistically. Therefore it is not surprising that the biopsychosocial model of health has been seen as an alternative to “old models” such as medical and social models and sometimes it is referred to as the “new paradigm of health” (Pender, 1996, Tones and Green, 2004).

In the context of this model, it has been argued that health benefits can potentially be accomplished from positive changes that could occur in any health dimension (Benson and Stuart, 1992). In light of this, health is a balanced reaction among different elements such as physical, mental and social which, are vital in maintaining good health. Other authors developed this argument further by asserting that a multidimensional perspective of health is empowering as it opens up multiple options for improving health status (Davey et al, 2001, Seedhouse, 2004). Viewing health from the biopsychosocial model could also benefit the research in health-related disciplines. For example, it could open channels for employing different research methods when health related topics are to be examined. Tones and Tilford, (2001)

argue that conceptions of health need to be studied quantitatively and qualitatively to cover a wide range of overlapping issues such as genders and cultures. Thus, seeing health as a multidisciplinary concept is a stepping-stone to examine holistically health determinants of a certain group of individuals.

However, whilst its philosophy is rooted in the holistic understanding of health, biopsychosocial model of health represents a framework of multiple parts rather than an integrated whole (Chaves et al, 2005). Evidence has shown that people's understanding of health is beyond the components of the biopsychosocial model as shown in the next sections. Mainly spirituality is missing in the model. Such a dimension of health has great importance in many cultures and should be addressed if health is to be seen in a holistic way (Lo et al, 2002).

Ewles and Simnett (2003) expand this argument and assert that spirituality could be considered as a central dimension of health as it might include different components. They found that, for some people, spiritual health is connected with religious beliefs and practices or principles that affect their behaviours. For example, it was found that Arab men during the fasting month "Ramadan" are likely to give up smoking (Hjelm, et al, 2005). Praying for God to heal chronic illness was also found as an exercise among Hispanic and South Asian people (Davey et al, 2001). Whilst spirituality and religious beliefs are interrelated and perhaps have an impact on people's behaviour, the concepts are slightly different.

It is reported that the dimensions of spirituality include interconnectedness, transcendence of life and belief in sacredness of life (Riley et al, 1998). Debatably, Chaves, et al, (2005) contend, with the exception of belief in transcendence, that previous dimensions could be core elements of anyone's life regardless of their religious affiliations. Consequently, hospital nurses need to be aware of such dimensions that could be a fundamental factor in which the meaning of health is constructed and thus affecting health promotion work. In conclusion, the multidisciplinary view of health has marginalised spiritual health and thus it is unwise to claim that such a view of health is holistic. In nursing practice, if health is

to be seen holistically, all aspects of health need to be taken into account. It is argued that health is a subjective experience and only becomes fragmented in the minds of health professionals in general (Pender, 1996). In line with this, it was found that nurses' care plans and, in particular their health promotion activities, are usually lacking a coherent view of health (Furber, 2000, Cross 2005, Irvine, 2007). Although further research is required to examine the validity of these findings, they raise questions about whether nursing has a humanistic and holistic view of health. Such components are a prerequisite for successful health promotion work (Tones, 2001, Seedhouse, 2004).

To summarise the models of health, it seems that whilst the medical model of health is useful in addressing physical health, it has a narrow focus on one aspect of health and epistemologically gives little attention to individuals' socio-economic context which influences their health status. On the other hand, the social model appears to provide a more accommodating framework for people's health needs. However, like the medical model viewing health from the social model poses some problems manifested by the exclusive focus on the social system, which is comparable to the medical model's focus on medical indicators (Tones, 2001).

The weakness of the medical and social models of health has resulted in generating the biopsychosocial model. As it is a multidisciplinary driven model, it has a more coherent view of health and thus health promotion than the medical and social models. In the light of this, it can be argued that adapting the biopsychosocial model by hospital nurses is a cornerstone for effective health promotion work.

However, whilst its philosophy is rooted in the holistic understanding of health, the biopsychosocial model of health represents a collection of multiple parts rather than an integrated whole (Chaves et al, 2005). Specifically, the spiritual dimension of health is missing and thus to some extent like the case with the medical and social models, health is fragmented. On this basis, it seems that each model of health has its own flaws. Consequently, the idea of holistic care capturing all aspects of health might be a more suitable framework for hospital nurses' role in health promotion

than using a certain model of health focusing on one or two dimensions. However, the models together with the idea of holistic care are used to inform the analysis of data in this work.

In conclusion, it can be argued that whilst the models of health could be used by hospital nurses as a guideline to understand the relationship between a specific action and outcome to health (e.g. high fat diet and cardiac problems), they suffer from limitations. Therefore, nurses' role in health promotion needs to acknowledge the failure in drawing a coherent picture about the meaning of health. Although no one model is sufficient to fully explain health promotion behaviours, hospital nurses need to understand their suitability for practice (Naidoo and Wills, 2000). To this end, nurses need to examine how the health needs of individuals are specifically expressed and met in a certain culture rather than exclusively practising within a context of a pre-established model. This is to be further debated in the following section.

2.8 Cultural Construction Of Health

Although medical, social and biopsychosocial models of health might provide a framework for nurses in general to inform their health promotion work, they were largely generated and tested within the western paradigm of health (Pender, 1996, Tones, 2001, Seedhouse, 2004). On this basis, there are concerns that the existing models might not fit with other health care systems, specifically in Jordan. Thus, hospital nurses' health promotion work might be ineffective due to a cultural and theoretical conflict. This highlights the need for exploring the ideology of health and health promotion in certain cultures which could lead to a better developed and informed conceptual model for health promotion. This is illuminated below.

It is argued that people's culture, health beliefs and practices are a driving force for either positive or negative health behaviour (Tones and Green, 2004, McLennan and Khavarpour 2004). According to Helman, (2000) culture is considered as the "lens" that people use to view a phenomenon including their health. For example, in

discussing the folk and cultural behaviour of health among Mexicans, ill health was viewed as the result of sin and that it is a punishment from God (Higgins and Learn, 1999). By contrast Turkish People tended to believe that not taking medication is a good way to keep healthy and one popular verse according to Inandi et al, (2002, p.75) is:

“ Go to the doctor, to make his day. Buy the medication, to make the pharmacist day. Do not take medication to make your own day”.

Whilst evidence is limited, these cultural conceptualisations of health are similar to those reported in the Jordanian literature. More specifically, in Jordan, Islam and the family structure are contributing factors and driving forces in shaping the Jordanians' beliefs of health (Gharaibeh et al, 2005). The majority of Jordanians are Muslims who believe that illness and wellness are God's will. They use their praying to cure illness within the context of an extended family system (Haddad et al, 2004, Gharaibeh et al, 2005). In this type of system, the decision-making process about health is socially constructed, where all members of the family participate.

The above examples illuminate the fact that cultural beliefs and thus practices cannot be divorced from the overall community intention, for example to adopt health promoting behaviour. That is, people's health is influenced by their cultural beliefs and the way they interpret health. The importance of why understanding of health needs to be understood from the cultural perspective is highlighted by many authors (see below). Arguably, without awareness of cultural differences in terms of the meaning of health, Western values of self-reliance could cause conflict with families of other cultures who may not have such values (Hjelm, 2005). Others (Leininger, 1995 Kim-Godwin et al, 2001) found that health services could be perceived negatively by people when they fail to fit with their way of life, needs and cultural expectations. It was found that indeed the well-planned health care could make no difference to people's health when it disputes with their internal understanding of the meaning of health and related issues (McLennan and Khavarpour 2004).

On this basis, it is not surprising that misunderstanding the same concept in a society could lead to a lack of trust and respect between nurses and their patients (Martinz, 1999) and lead to misdiagnoses of medical problems (Andrews and Boyle, 1999).

More specifically, when there is a gap between health professionals' scientific knowledge and their patients' beliefs, this could lead people not to use the available health services but to also not approach health promotion activities (Zoucha, 1998). Some analysts go far to state that once the meaning of health is understood from its cultural roots, the racial and ethnic disparities that might exist in many health systems can be reduced (Smaje, 1995, Gallant and Dorn, 2001, Kim-Godwin, et al 2001).

Therefore, taking into account the cultural meaning of health would not only enhance the communication between nurses and their patients but also it maximizes the efficiency of the health care being delivered including health promotion and might overcome the inequality problems. In light of this it can be argued that an in depth understanding of health concept from both perspectives of caregiver and the culture of receiver is needed in the health care system as explained in the next section.

2.8.1 Health Care System as a Cultural System

The hospital, the focus of this study, has a symbolic meaning that shapes both social realities, patients' experiences, mediates between parameters of medical systems and their links to the community (Andrews and Boyle, 1999, Kim-Godwin et al, 2001, Tones Tilford, 2001). Given these overlapping elements, it appears that health care system might be viewed a cultural system. The latter system is of significant interest to the current research as it can be considered as a springboard from which health promotion activities can be generated. In order to reflect on such a complex system and due to scarcity of nursing literature on its dimensions, it was decided to use some related discussions reported in other disciplines. The medical anthropology literature offers this.

A seminal work by Kleinman, (1978) into medical systems as cultural systems could serve as a groundwork for illuminating the structure of the health care system and thus its appropriateness to both health and health promotion. Kleinman's cultural model was found to be a useful guideline to establish health care system services informed by cultural beliefs in a certain community (Zoucha, 1998, Yaoho and Ezeoble, 2002). According to Kleinman's, (1978) model which is reinforced by recent writings (Kim-Godwin et al, 2001), the health care system includes three social arenas within which health is experienced, shaped and reacted. These are popular, professional and folk. The popular, as reported in health promotion literature (Tones and Green, 2004), includes the family context of health and illness. It is considered as the most powerful arena in which most decisions related to treatment and health are made (Bolwing, 2005).

On the other hand, the folk arena consists of those non-professional health care and secular groups, whereas professional arena includes scientific professionals such as doctors and nurses. That is the social reality within the hospital setting is an outcome of the dynamic interaction of above arenas. It would be naïve therefore to divorce health care systems from both its social and cultural context.

However, the medical systems and cultural systems differ from one society to another and sometimes within the same sectors of the same society (Kim-Godwin et al, 2001). This implies that in-depth understanding of health and health promotion within a particular health setting and culture is desirable. In light of this, the current research has exclusively focused on one hospital with the boundaries of a specific culture (See Chapter 4: Health Promotion Literature).

2.8.2 Cultural Health : Implications for Hospital Nurses

The ideology of a health care system as a cultural system has implications for hospital nurses' role in health promotion worth consideration in this review. They are on the front line of health care delivery and are often challenged to deliver

culturally competent services (Kim-Godwin et al, 2001). Considerable evidence reveals that, when hospital nurses are aware of diverse interpretations of health, the possibility of making positive changes in public health will be greater (Smith et al, 1999, Yaoho and Ezeoble, 2002). Hospital nurses are likely to be exposed to different cultures and backgrounds. Arguably, if nurses are to productively offer health promotion activities, they should understand these differing cultural norms and how people conceptualise health (Yoho and Ezeobele, 2002). This argument has been taken forward by McLennan and Khavarpour (2004) who stresses that there is a need for “culturally competent health promotion activities”(p236).

Although little is written about this concept in the nursing literature, it is meaningful as it fits with people’s cultural beliefs and lifestyle and consequently could enhance their willingness to get involved in such “specialised” activities. Given this connection between people’s cultures and health beliefs, hospital nurses can minimise cultural barriers by being aware of cultural values of health through having respect for the differences. This will be illuminated with evidence from nurses’ practice later in the findings of this thesis.

Yaoho and Ezeobele, (2002) argue that health promoters, like hospital nurses, need not only to gain theoretical knowledge about health promotion itself but also on how health is interpreted culturally in the health care system itself. Therefore: “Cultural competence in today’s borderless societies is necessity not a luxury and learning from [patients’ beliefs] an additional requisite for effective trans-cultural competence in clinical practice” (P: 27) (Yaoho and Ezeobele, 2002). Whilst there is no agreement in defining “cultural competence”, it has key elements. This involves cultural skills (e.g. the ability to examine cultural health needs) and the awareness of cultural behaviour of a certain group of people (Smaje, 1995 McLennan and Khavarpour, Kim-Godwin, et al 2001). On this basis, it can be argued that culturally competent nurses can incorporate aspects of patients’ own interpretations of health in their care plans. Doing so would result in increasing patients’ satisfaction about

health care being delivered to them as well as motivating them to use the available health care services (Young, 1996, Lee and Newberg, 2005).

Following this line of argument, evidence also suggests that when health care providers work with patients' beliefs rather than against them the outcomes are more successful (Hjelm, 2005). Consequently, the increased understanding of the subjective experience of health might result in a better informed and likely a more successful health promotion strategy. That is, research into the meaning of health is not only desirable - rather a prerequisite for establishing health promotion within a specific cultural environment (Paxston et al 1995, Tones and Green, 2004, Ewles and Simnett, 2004).

However, this is not the case. The review of literature has revealed that the concept of health has been marginalised by international research with particular reference to nursing literature. Whilst there are significant studies about health promotion in nursing as explored in the next chapter, limited evidence is obtainable in the literature about how nurses themselves and their patients view health. To date there is no Jordanian study to examine both nurses' and patients' understanding of health to facilitate offering congruent cultural health promotion activities as outlined above.

The importance of examining the meaning of cultural health in Jordan stems from the fact that the health service is under development and health promotion is yet to be incorporated into different settings. As pointed out by a number of authors if health care is to be enhanced in a certain society, the meaning of health should first be examined (Bowling, 2005, Tones and Green, 2004). McLennan and Khavarpour (2004) expressed their concerns about the extensive attention given to health promotion while the meaning of health in specific societies is still not fully exposed. To place the current study's findings within the context of international empirical literature, the next section examines the relevant studies about the concept of health. The need for more research in this area is identified and the extent to which the debate about health in this chapter has been addressed by empirical work is highlighted.

2.9 Studies into the Meaning of Health

The review of literature has located very few studies that have examined the concept of health from the perspective of lay people and nurses. Some were largely informed by the WHO's definition of health and the majority of these studies were in Australia and the UK (see Below). Different methods were utilised and their findings were mainly guided by the qualitative approach. On reviewing the Middle Eastern literature, a single study has been found which could offer some knowledge about the meaning of health within the Arabic culture (Hjelm et al, 2005).

In order to offer an inductive account of each earlier work, the studies were categorised into three groups. The first group includes those studies which have been found in the sociology research. Whilst they had a nursing focus, the methods employed and the emanating data are relevant to the study review. The second group includes more specifically those studies in the nursing literature. Thirdly, this group focuses on the Middle Eastern literature. The implications, together with a critique of the located studies, are given in the following sections.

2.9.1 Sociological Studies on the Meaning of Health.

Sociological literature offers two studies (Dickinson and Bhatt, 1994, Paxton et al (1994) that focused on the meaning of health. Whilst they are now more than a decade old and need to be replicated with different samples to verify their findings, they are popular in the literature and of relevance to the current study's methods and scope. A multicultural study by Dickinson and Bhatt (1994) explored the ethnic minority communities' understanding and attitudes towards health in England. Using semi-structured interviews, the researchers surveyed a sample of 277 respondents from the community of Chinese, Afro-Caribbean and South Asian men and women aged between 35-64.

Quota sampling was used to involve equal numbers of respondents (n=40) from different language groups consisting of Chinese, Bengali, English, Gujarati, Hindi,

Punjabi and Urdu. Dickinson and Bhatt (1994) ensured that the sample involved the key religions such as Christianity, Hinduism, Islam and Sikhism. Thus, it seems that the quota-sampling procedure was effective in terms of enhancing the representation of ethnic different minority groups, gender and religion. However, the quota sampling shares similar weaknesses to the convenience sampling method such as the lack of generalisation and control over bias. Indeed, the possibility of selection bias in this study is likely to be high. This is not only because of the absence of a probability sampling procedure but significantly due to the fact that local interviewers who collected the data were known to their communities. To add to the problem, they had no training or previous experience in undertaking interviews - for example, to minimise the possibility of leading questions. That is, the credibility as well as representativeness of collected data is in doubt.

Nevertheless, the interviewers (n=7) were urged to complete 40 interviews each. Open-ended questions were translated and written on to each interview schedule in English. The reliability of the translated questions and the respondents' answers were not established and thus the responses validity is open to debate. The interviews were recorded and then transcribed for analysis. No detailed information was given about the open-ended questions, but respondents' attitudes to health were measured by introducing them to 13 statements. They were asked to indicate their agreement by using a 5-point Likert Scale ranging from Strongly Agree to Strongly Disagree. The statements asked the respondents about the causes of health and illness and their own role in maintaining health and the treatment of ill health. According to Dickinson and Bhatt (1994), the statements were developed from the literature review but no particulars were given regarding their validity and reliability. However, the review of some items would raise some concerns about the overall quality of these statements. It is reported that the 13 statements were about "perceptions of and attitudes to health", but many items were structured around the medical model view of health and particularly illness as exemplified below:

"Most illness could be prevented if people paid more attention to what they eat"
"I would have to be very ill before I would go to doctor"

As outlined above, it seems that the statements do not represent different aspects of health meanings in social and positive health such as happiness and consequently their validity is likely to be low. Moreover, the reliability of the statement 7 in Table (1) is flawed.

“People like me do not really have time to think about their health”. (p: 425)

The statement is too confusing to understand. For example, how could participants know if other people have time for their health or not? Further, whilst Dickinson and Bhatt (1994) have stated that open-ended questions were used, no single respondent's quotation is mentioned to enhance the credibility of the findings.

The findings showed some similarities between the different groups of respondents. Most of them were concerned about their health. However, Chinese men (65% n=180) and women (40% n= 110) believe that health is a matter of luck. The authors did not attempt to explain such a result - this is because the study was “explorative and its results were suggestive”. However, linking luck to health could have negative outcomes to an individuals' motivation to change unhealthy lifestyles (Davey et al, 2001) and perhaps could get engaged in health promotion activities. It is difficult to explain why Chinese respondents view health as a matter of luck as no qualitative data were offered to gain more knowledge about such a link. However, the authors did mention that “Chinese respondents on the whole did not ascribe to religious faith” compared to other respondents such as South Asians. Only 37% (n=14) of South Asians said that health is a matter of luck. Although there is lack of evidence from Dickinson and Bhatt's (1994) study, it could be suggested that religious beliefs are likely to lead people to think that health is not a matter of luck rather “something” controlled by God and people need to have significant responsibility to maintain it. This assumption has been supported by cultural studies (Yoho and Ezeobele, 2002, Hjelm et al, 2005). Almost half of Caribbeans (51% n=141) and South Asian people (51%,n=145) felt that ill health sometimes had some divine

purpose. These results again stress the importance of spirituality and health as discussed earlier in this chapter.

Dickinson and Bhatt (1994) concluded in a quantitative way that in general the majority of respondents had positive attitudes to health and towards their role in maintaining it. However, this conclusion is not adequately supported by empirical data. The authors themselves commented that the “findings are not more than suggestive” (p.427).

On the whole, the study of Dickinson and Bhatt (1994) interestingly points out the complex reality of the meaning of health among different ethnic communities. But it suffers from significant limitations including the possibility of selection bias, the lack of generalisation and the poor validity and reliability of statements used. That is, the study made very limited contribution to this body of the literature and it would not be possible to draw any conclusive evidence regarding the cultural nature of health. Subsequently, a more recent qualitative work is needed to offer further in-depth insights into the meaning of health and, in particular, to its link with health promotion.

A further sociological study has examined the concepts of health among Australian men (Paxton et al, 1994). Once again semi-structured interviews were conducted with 55 respondents over the age of 35. The sample has included those who were willing to participate from a cross-section of occupations within local and state government organisations. Whilst no sampling frame was used, the authors claimed that the sample did represent a cross section of occupational groups. The sample consisted of 38 participants from blue-collar occupations (e.g labourers on road sites) and 17 from white collar areas (e.g administrators).

Thus, the possibility of selection bias cannot only be ruled out but also the sample number of the first group is not equivalent or even close to the sample size in the second group. This might indicate that the credibility of comparisons made in this work between the two groups might be open to question. Although no sufficient

details about the content of the interviews' were given, the authors stated that some questions were developed from the relevant literature. However, all the interviews were conducted by a trained nurse, and then they were transcribed. The findings were that Australian men view health as the absence of disease, physical fitness, functional capacity, strength and psychological well-being. No mention was made about the social factors such as income and health services, which could determine health status. The authors were surprised as these factors are according Paxton et al (1994) vital in determining the health status of Australian people. However, this might be explained by the low sample size used in the study, which could have covered the importance of such factors.

Sixty percent of respondents (n=33) mentioned that some forms of behavioural responses could cause illness. The authors explained this result as a sign of the success of health promotion programmes in Australia in increasing awareness of the link between people's behaviours and disease. This rationalisation could be true but research has shown that understanding of health related issues is not always an outcome of effective health promotion programmes. For instance, people can learn about health from a previous episode of illness or from other health experiences (Pender1996, Davey et al, 2001). Consequently, given the lack of correlative data on this issue and the study's small scale, it seems that such a link needs further investigations employing larger sample size as well as different methods. The overall findings offer a number of vital insights into Australian men's understanding of health, which need to be considered if their health is to be promoted. The thoroughness of these findings, however, is weakened by a number of gaps as outlined above. The authors suggest that both men and women' understanding of health is essential to facilitate comparisons (Dickinson and Bhatt, 1994) but it also would be desirable to include participants from other settings to enhance drawing a more coherent picture about the meaning of health. The findings reflect attitudes towards health in the workplace setting but the extent to which these results are applicable for example to those patients in a hospital setting, is still largely unexplained in either quantitative or qualitative terms.

Taking the sociological studies together, they provide interesting insights into the concept of health. Nevertheless, despite the differences in the populations and sampling procedures, the two studies share the same weaknesses. This consists of the low generalisation due to the small sample size, the possibility of selection bias of participants and the limited evaluation of the meaning of health within the context of considerable debate about its nature. Importantly, the validity and reliability of the methods employed are indeed questioned (Dickinson and Bhatt's, 1994).

Paxton et al's (1994) study has focused only on men and thus it is not possible to assume that women view health from the same perspective. This sheds light on the need for a more systematic empirical work including both sexes. As they were both undertaken more than a decade ago, more research is needed to validate their results. Finally, the majority of conclusions are based on quantitative data and as such the "subjective experience of health" as commented on previously is still mainly unexamined. The researchers in the next section have attempted to adopt a more qualitative approach in their studies.

2.9.2 Studies into the Meaning of Health from Nursing

It is argued that nurses' understanding of health could shape their health promotion role and affect the way they approach health promotion (Tones and Green, 2004). Yet it is surprising to find limited research on the meaning of health in the nursing literature. The reason for this lack of research on the concept of health is not obvious. From the review of health promotion-related studies, as reviewed in the next chapter, it seems however that nursing authors presuppose that nurses have sufficient knowledge about health and thus researchers paid more attention to health promotion. Another reason could be related to the fact that the concept of health, unlike health promotion, has been developed for a long time and it is expected that health care providers such as nurses are already familiar with it. These explanations lack empirical evidence but are worth mentioning and of course need more research. Nevertheless, the study discussed below, despite its limitations, has revealed that nurses do not have a comprehensive view of health. A small-scale research by Herbert's and Eriksson (1995) examined the view of health among nursing leaders

(n=20) and members of staff (n=49). Given this aim, it was expected that the reviewed literature would be a focus on health related models, but the literature was mainly guided by caring related models. Whilst the link between health and care is acknowledged, the study evaluation of health concept was limited and has been placed within a narrow context of health concept literature.

Data were collected by a questionnaire. It was designed to include open-ended questions about the meaning of health as a multidimensional concept. No further information is given about the questionnaire's validity and reliability and thus its quality is open to debate.

As the obtained data were qualitative, content analyses was selected by authors (Herbert's and Eriksson's, 1995). However, there are some concerns about the rigour of analysis itself as it appears that the focus was on the findings rather than on the processes of analysis itself. An independent researcher was not involved in the analysis process to enhance the reliability data. Moreover, the transcribed data were not validated by participants.

According to Herbert's and Eriksson (1995) some extracts from the participants were provided in order to be judged by readers and enhance the credibility of the study. Consequently, Herbert's and Eriksson (1995) go further to claim that the "inter-subjectivity of the study was preserved". Given the fact that inter-rater reliability of neither data categorisations nor responses validation procedures were utilized, it would appear that such a claim is lacking accuracy. Nevertheless, some findings of relevance are offered by the research.

The main findings were that nurses and nursing leaders have a multi-dimensional view of health but the "higher dimensions" of health are not always apprehended and explicitly expressed. These findings however are confusing as it is not clear what the meaning of "higher dimension of health" is. If there is a higher dimension of health, logically it can be argued that there is a lower dimension. Dividing health concept in this way conveys somewhat of a misunderstanding of the holistic meaning of health.

As discussed earlier in this Chapter, the diverse dimensions of health such as physical, mental and spiritual are integrated. Consequently, it is not possible for example, to claim that physical health is more important than either mental or emotional health.

According to the findings, nurses were more likely than nursing leaders to emphasise physical health. Nursing leaders believe that patients' view health as well-being whereas nurses think that patients see health as the absence of disease. These findings are vital but also worrying. Herberts and Eriksson (1995) did not attempt to discuss them adequately perhaps because of the lack of reviewed theoretical literature about health concept. As the reported extracts have not been clearly linked to either nursing leaders or nurses, it is not possible to examine the emerged themes. It appears that nurses' views of health are dominated by the medical model of health. Importantly, as nurses view health as physical ability, they think that patients have the same view. However, the credibility of this finding is threatened by the fact that patients were not involved in the study to verify this postulation. Despite this, Herberts and Eriksson, (1995) concluded that

“There is incongruity between what one thinks one is able to do to promote one's health and what one sees as the most important factors for health” (p: 877).

Obviously in order to verify the above conclusion empirically, it would seem that there is a need to explore both nurses' and patients' understanding of health in order to examine the extent to which their interpretations of health are congruent.

Briefly, Herberts and Eriksson's (1995) study is acknowledged as it is the only work that attempted to examine specifically how nurses and their leaders view the concept of health. However, the study is confined by the lack of theoretical background about the meaning of health and the possibility of selection bias. Moreover, the study is more than a decade old now and as suggested by the authors themselves, it needs to be replicated with a larger sample size, different methods and populations of nurses

to examine its validity. In the light of the above constraints, Herberts and Eriksson's (1995) study adds little empirical knowledge to the body of literature in this area.

A further qualitative inquiry from American literature has examined the meanings attributed to health from elderly women's perspectives (Maddox, 1999). The researcher has moved beyond the quantitative approach as is the case with Dickinson and Bhatt (1994) and a phenomenological investigation was undertaken. Hence health is a subjective experience, it is expected that in-depth personal's account about how health is conceptualised among elderly can be offered from this work. Although no sufficient details given about the selection procedure, it is reported that three separate groups of women aged 55 years were included.

The sample encompasses 12, 8 and 5 participants respectively. Unstructured interviews about the meaning of health were undertaken. The data were audio-recorded and then transcribed by the researcher. The transcribed data were given back to the participants for clarification and correction and some changes were made. Therefore it can be assumed that the trustworthiness, to some extent, of this work has been enhanced in terms of credibility. There remain, however, some concerns about other criteria of the overall rigour of this study with particular reference to its conclusion as progressed below. The credibility of this qualitative research is open to question as no independent researcher had been involved in both coding and categorisation process. That is the inter-rater reliability was not established and thus it is unwise to consider the data trustworthy. Moreover, the results transferability is indeed uncertain. This is due to the remarkable lack of knowledge about the context, in which the data were collected and analysed. However, despite the above difficulties some findings are of significance.

It was found that elderly women view health differently and their interpretations of the meaning of health have been addressed by a number of themes (Maddox, 1999). This includes, attending religious activities particularly in the church. Likewise, women have highlighted the importance of praying regularly to God for both an

illness and wellness status. Yet these findings are not surprising as all the women were nuns.

Using a sense of humour to reduce their stress was reported as an intervention among women. Being with their friends and families is considered as part of good health. However, in addition to these themes, from the examination of some reported extracts, it was noted that there is a key theme missing that has not been explored by the researcher (Maddox, 1999). As no inter-rater reliability has been established, this indicates that the analyses process did not fully examine the entire thematic patterns emanating from the transcriptions. For example, one nun said that:

“I am retired now after I was teaching...my golden years gone now. I was told to take it easy and do absolutely nothing” (p.29).

This expression sheds light on the fact that being independent and having a job regardless the age group is vital for elderly. That is, nurses perhaps as health promoters need to address this piece of evidence suggesting that the elderly should not be deemed as unable to carry out their daily life but of course within a realistic extent.

The study concluded that incorporating women’s understanding of health, regardless of their culture and socio-economic backgrounds, could lead nurses to better help this population to maintain good health. However, it is surprising that the conclusion devalues the importance of people’s background in formulating their own images about health. For example, it would not be possible to fully understand people’s perceptions of health and thus health promotion without having some premises about their culture. In light of the above limitations, it would be difficult to draw any credible implications that could inform health promoters’ agenda such as hospital nurses. This is coupled with the fact that the study has focused only on elderly women and thus more research is needed to include men and other age groups. Yet this point has not been addressed.

Yoho and Ezeobele, (2002) examined the meaning of health among older Hispanic Women. “A sample” including 19 Hispanic women ages ranged from 61-82 was selected. The authors failed to provide detailed information about the sampling procedure and thus it would not be possible to exclude the possibility of selection bias. This is vital as the participants were selected from a health care centre. The participants were interviewed using semi-structured interviews. The interviews were designed to ask about the meaning of health. The questions were read from a typed form and their immediate responses were documented. Interpreters were used for those participants who spoke Spanish. Whilst this was essential, the interpreters might have summarised the participants’ responses, which could lead to losing valuable information during the process of translation. The data were analysed using the ethnographic approach. This approach was suitable as it examined the cultural interaction and conceptualisation among the participants (Gillis and Jackson, 2001). However, no details were given about the analysis process to facilitate the examination of the credibility of the data.

Being healthy was viewed by women as being independent and having the ability to do the daily activities. Moreover, they are likely to use folk remedies such as consuming vinegar with garlic and honey to keep blood pressure down. No exact number was given but Yoho and Ezeobele, (2002) stated that “most women” talk to physicians and their sons and daughters when they feel ill. Walking was found to be the common activity used to keep healthy. Interestingly, they pray to God to heal them from illness. The above findings, however, were not adequately discussed in the context of international research or to related theoretical backgrounds of the concept of health. The lack of an efficient analysis of data could be explained by the very limited references (n=7) used for this work. This small-scale work has some implications of relevance to nursing practice as well as the current study. For instance, nurses need to promote independence level of older women in order to enhance their quality of life.

Nevertheless, the study’s findings are constrained by the lack of a theoretical framework of the meanings attributed to the concept of health. As the case with

Maddox's (1999) study, Yoho and Ezeobele (2002) have exclusively focused on older women and thus it is not possible to assume that the results are applicable to men. However, Yoho and Ezeobele (2002) have argued that nursing needs to expand its research capabilities and examine opportunities for qualitative research in the exploration of culturally related health issues. The current study reacted to this call.

2.9.3 Studies into the Meaning of Health from the Middle East

The literature has shown that the meaning of health has been somewhat marginalised in the literature. It is not surprising therefore that no study was found to examine the meaning of health specifically from the perspective of hospital nurses and patients in Jordan. By reviewing the related research in the Middle East, the search found only one study that has included some Arab participant (Hjelm et al, 2005). This was striking as the investigation of the meaning of health among lay people, as well as health professions, is crucial for establishing health promotion as well as delivering holistic health care services (Bowling, 2005). This is of significance to Jordanian hospitals, as according to Mahasneh (2001) they need to offer the Jordanian community a high level of evidence-based health care.

Hjelm et al's (2005) has exclusively focused on diabetes health care management and the meaning of health among different ethnic groups in Sweden. Whilst the study did not include participants from Jordan, some findings are of importance to the current research as they were elicited from Middle Eastern participants. Moreover, the method utilised i.e. focus group discussions is one of those methods used in this study, which could offer some insights into their usefulness when it comes to the investigation of health related issues. The study's implications, together with critique, are addressed below.

Swedish researchers have attempted to uncover the health belief of men with diabetes who were from different cultural backgrounds and living in Sweden. Hjelm et al (2005) suggested that diabetic patients' belief might affect self-care and care seeking behaviour and health promotion in general (Hjelm et al, 2005).

A purposive sampling procedure was used and once again, as in previous studies (Paxston, et al, 1995, Yoho and Ezeobele, 2002,), the possibility of selection bias cannot be ruled out. In fact, such a possibility in this study is likely to be high as the sample was recruited by a female nurse who knew some of the participants.

Focus group discussions were held with 35 men with diabetes aged between 39 and 78 years. The sample was comprised of 14 who were born in Arabic countries [Iraq=9 Palestine=2, Lebanon= 2 and Egypt =1]. Other participants (n=10) were from former Yugoslavia and 11 were born in Sweden. The specific number of the group discussions held is not given, but Hjelm et al, (2005) stated that the number was “determined by the principle of saturation in data analysis” (p: 40). Yet from the findings it appears that no further themes have emerged from the discussion at any time. This is by no means unusual in qualitative research using group discussions, which usually generate further knowledge at the time of interaction with the participants (Morgan, 1997). Therefore, the benefits of “principle of saturation of data” in Hjelm et al’s, (2005) study are questioned in terms of in-depth exploration of data.

A specialised diabetic nurse not involved in the management of the patients, undertook the facilitation of focus group discussions. Each discussion has included either three or four participants in order to “minimise the need for interpretations”. However, whilst the sample used could be more manageable, it is argued that each focus group discussion needs to include a range of 5-12 participants to allow adequate interaction (Morgan, 1998) and thus the sample of three or four raises some concerns about achieving such an objective. Hjelm et al, (2005) acknowledged this limitation but surprisingly they have made a somewhat inaccurate claim by stating that:

“ The small sample size [of participants] are recommended when the prime objective is to obtain the maximum amount of information] (p: 57).

The above statement contradicts the fact that the larger sample size (5-12) is likely to generate more information than, for example a sample of three participants, of course if the discussions are well moderated. The discussions were about the meaning of health, health behaviours and illness causation and no further information was given about how the discussions were moderated. For example, to avoid leading questions and interpret non-verbal communications and thus it would not be possible to examine the validity of obtained data. To add to the problem, the actual purpose of the discussion is surrounded by significant vagueness. The study was explorative which implies gaining in-depth lay insights regarding the meaning of health related issues from the participants. A reported statement by Hjelm et al, (2005) would indicate that the purpose was likely to be “educative” rather than “explorative”. The following quotation illuminates this:

“ Many respondents particularly, Arabs, expressed positive experience after the interaction and said that they have not only been interviewed but also have gained knowledge about diabetes and its management” (p:57).

Therefore, it can be argued that the diabetes-educated nurse who moderated the discussions perhaps did not control her role as an educator throughout the research. All the discussions were audio recorded and then transcribed independently by two researchers. The independent analysis has shown a high level of agreement. However, due to the limited details about the study’s context, the transferability of results and thus trustworthiness is indeed in doubt. The health belief model was used to inform the categorisation phase of factors, which could affect diabetic patients’ health. Using this model during the analysis process raises some questions about its effectiveness in exploring related themes to the meaning of health. Its views of health are rooted in the medical model (Bunton and Macdonald, 2002) as discussed earlier in this chapter; such views of health treat people like machines that need to be fixed. The health belief model has been increasingly criticised because of its exclusive focus on preventive health (Tones and Green, 2004).

Indeed, throughout the study Hjelm et al (2005) have an assumption that the health belief model's components (e.g. perceived seriousness of illness) have an impact on making decisions about following certain health behaviour. However, this is not often the case. Many scholars have found that following certain health behaviours can be determined by other factors such as motivation (Pender, 1996, Tones and Tilford, 2002). Indeed, research has shown that there is a modest link between the health belief model and people's behaviour (Bunton and Macdonald, 2002). On this basis, the effectiveness of using the health belief model in Hjelm et al's (2005) work as an analysis guideline is called into question.

Nevertheless, despite the difficulties, there are some key findings that have emerged from the study which are of interest to the current research. Swedish men have focused on healthy lifestyle such as avoiding smoking. In contrast, Arabic and Yugoslavian men paid significant attention to economic factors and the cost of medical treatment. Arab men have shown a more active information seeking behaviour than both Swedish and Yugoslavian men. The meaning of health among Arab men, as well as Swedish was around the notion of the free from illness status. What is more, Arab men emphasised the ability to fulfil their roles in society "bringing up children and being a breadwinner".

Religion was considered to be of importance for all except one of the Arabic group. They described praying in terms of giving relaxation and mental peace. These results are similar to the earlier reviewed work by Yoho and Ezeobele (2002 study). Despite the differences between Hispanic women's culture and Arabic culture, praying was deemed as an important dimension of health. This indicates that the link between health and praying is fundamental in people's health despite the differences in cultures and religions. With regard to social health, Arabs have expressed strong concerns about the importance of social life to their health status. For example, during Ramadan they meet each other and eat together. An interesting finding which emerged was that Arabs were more motivated to gain knowledge about health related issues than Swedish and Yugoslavian men. Although this finding might not be

generalisable due to the small sample size (n=14), it is indicative that Arabs are willing perhaps to get involved in health promotion activities.

Hjelm et al (2005) argue that teaching needs of diabetic patients should be individualised yet such a health education approach has a limited focus on the individual, which often marginalises other related factors such as economical status of individuals. This approach is widely charged as victim blaming as explained in the following chapter.

In conclusion, Hjelm et al's (2005) inductive study proffers some valuable findings about the diverse views of health among ethnic groups in Sweden. This could help in establishing cultural care and thus health promotion activities. However, the study's findings should be taken cautiously given the drawbacks outlined above. Indeed, the study has focused only on men and thus the findings are possibly not applicable to women.

As Arabs had been living for a long time in Sweden perhaps the findings might be different if the study had been replicated with a sample from Middle Eastern participants. The dissimilarities between the Swedish and Middle Eastern environments as well as the quality of life could have resulted in some changes in immigrated Arabs' understanding of health. Nevertheless, it is worth noting that Arab cultures are similar but not identical and each Arabic country has its own traditions and principles of living (Brewer, 2004). Because of the absence of Jordanian participants in the Hjelm et al's (2005) study, the qualitative findings applicability to Jordanian population is questioned. There is therefore a need for up to date research addressing the meaning of health from a Jordanian perspective.

2.10 Conclusion of the Chapter

This chapter explored the meaning of health and related studies within the international and Jordanian contexts. It argues that unless health is understood from people's own cultural perspective, promoting it would indeed be a multifaceted mission for hospital nurses. However, against this backdrop, the literature has revealed that the international nursing research lacks empirical data about the meaning of health in particular from the perspective of hospital nurses and patients. To date the majority of literature available on the meaning of health is largely guided by theoretical debate among authors themselves rather than by empirical means. Well over a decade ago Paxton et al (1994) criticised the very limited empirical knowledge about the meaning of health in particular cultures. Now this chapter has suggested that very little research progress has been made.

The reviewed literature reveals paucity of well-developed empirical positions, which could be neatly summarised and compared with the trans-cultural work. Instead, most of the literature is taken up with studies that often do not specify the theoretical framework and therefore drawing conclusive evidence is a difficult task (Maddox, 1999). Further, reported studies have tended to be small-scale research, do not offer statistically significant findings, by focusing on only one gender or age group, who were too old and their conclusions were not verified by replication. They are threatened by little attention given to the rigour issues -e.g. trustworthiness (Dickinson , and Bhatt 1994, Paxston et al, 1995, Herberts and Eriksson, 1995, Maddox, 1999, Yoho and Ezeobele, 2002, Hjelm et al, 2005).

Advances in the conceptualisations of health among hospital nurses and patients have not yet been empirically matched together within a health promotion context. That is, offering congruent health care as argued in the literature (McLennan, and Khavarpour, 2004) that could decrease the fear of health services, maximise the respect between patients and nurses and enhance the overall community's well-being is not possible.

Likewise, the available evidence gives very sketchy directions for reforming cultural health systems towards the movement of health promotion as explored in the next chapter. Subsequently establishing culturally congruent health care as well as health promotion activities will not only be lacking empirical guidance (Higgins and Learn, 1999, McLennan and Khavarpour 2004) but also their cultural applicability will be in doubt (Kim-Godwin et al, 2001). Whilst there are very few Jordanian studies about health promotion (see the following chapter), no study was found which addresses exclusively the meaning of health in Jordan. The current research therefore attempts to bridge this gap in the literature. This is because the future of health care depends not only on scientifically based evidence but also on recognition of population diversity and both health professionals and people's cultural understanding of health itself (Kim-Godwin et al, 2001, Jones and Donovan, 2004).

Once both hospital nurses' and patients' understanding of health is identified and verified by the literature, hospital nurses, as health promoters, can incorporate them into the framework of the patient's daily care plan to achieve a higher level of their self actualisation and thus compliance with the prescribed treatment (Maddox, 1999, Seedhouse, 204). This chapter can be considered as a theoretical background to formulate the context in which both hospital nurses' and patients' understanding of health as well as health promotion is examined.

Chapter Three: Health Promotion and Nursing

3.1 Introduction

Building on the premise of debate attributed to the meaning of health in the previous chapter, the literature moves on to explore health promotion related issues. It is argued that health professionals are unable to theoretically define and delineate exactly what constitute to health promotion and health education as their effectiveness depends on sound theory (Paley, 1996, MacDonald, 2000, Casey, 2007, Whitehead et al, 2008). This chapter falls into two parts. The first part sheds light on the ideology of health promotion together with related theories and models. The features of the empowerment model for health promotion, its implications together with its limitations are debated. The health promoting hospital movement is discussed and the nurses' role in health promotion is examined.

The second part examines the extent to which hospital nurses' roles in health promotion is addressed by empirical work. Thus, this chapter forms a theoretical background against which the available studies in the literature and the emerging findings from this work are discussed.

3.2 Health Promotion Concept

Many issues underlying the concept of health (e.g. the social and medical models) were discussed in the previous chapter, compared and contrasted. Thus health promotion will not be extensively explored here. Instead, attention is given to what constitutes its features in relation to hospital nurses' role in health promotion.

The review of the literature indicates that the concept of health promotion has been understood differently by many writers (see below). There are a number of definitions of health promotion in the literature and thus it was decided to trace their backgrounds. The most common definition is that health promotion is a process of enabling people to increase control over and improve health (WHO, 1986).

Although the definition is not free of shortcomings, as discussed below, it is still frequently cited in the literature (Tones and Green, 2004) and adapted as a framework for health promotion studies especially within the nursing context (Cross, 2005, Whitehead et al, 2008). Thus, the definition is critically analysed in this review.

The WHO's definition of health promotion has played an important role in highlighting the complexity involved in health promotion. According to its ideology, individuals are encouraged to take control over their health and make informed choices in a certain environment. This occurs as a "process" involving actions at both individual and structural level (WHO, 1986). Whilst the latter action focuses on building public policy and fiscal measurements, the former is more concerned about the development of personal skills, which contribute to positive health.

However, operating at two complex levels is not a straightforward process. It is argued that health promotion needs certain mechanisms to reach that end (Ewles and Simnett, 2004). This includes an emphasis on advocacy, creative supportive environment and mediation between different groups to ensure persistent health (WHO, 1986). In line with this, other scholars stress that such actions require to be placed within the health services advocating health promotion itself (Tones and Green, 2004). Thus, health promotion not only operates at the level of individuals and community but also focuses on building a health care system that is conducive to health. Having stated this, while individuals need to take some responsibility for their health, mechanisms to allow this to happen need to be offered as outlined above.

Although the contribution of the WHO's definition to health promotion is recognized, it has been under attack. It is argued that the definition is vague and lacks precision creating "an illusion of shared" meaning whereby care providers assume they hold a collective understanding the term health promotion (Seedhouse, 2004). On this basis, this argument returns us to the problem related to the conceptualisation of health itself. That is, it seems that both health and health promotion are understood

differently by individuals. Within the hospital setting, this might act as a barrier for multidisciplinary health promotion work due to the adaptation of different understandings of health promotion. This is consistent with hospital nurses' role in health promotion which focuses on individualised health education actions poorly articulated with an understanding of the multidisciplinary nature of health promotion. There is little wonder therefore that, in reality, the practice of health promotion in general is often based on ambiguity and value judgment (Seedhouse, 2004) and in nursing is opportunistic (Whitehead, 2004, 2005). In light of this, the assumption that health professionals such as hospital nurses have an agreement on what can be labelled as health promotion is faulty. On this basis, there is a need to examine how health care providers like nurses understand the concept and translate it in practice before being urged to be involved in health promotion work.

A further criticism of the WHO's definition is related to the mechanisms associated with it (e.g. advocacy and the creation of environment supportive to health). They were criticized on the ground of "a catch all framework" for health promotion in which priorities are vague (Jones, 1997). Likewise, it might not be fair to expect a group to operate at all levels for health promotion without identifying certain limits for the practice and their contribution (Duaso and Cheung, 2002). Taking these arguments together, the definition is too broad to use as a framework for health promotion activities. This was coupled with confusion about what degree of control is needed to allow people to make informed choices.

This confirms that health promotion is complex and multidimensional due to political and philosophical perspectives that might shape its practice. Health promotion is being used in many contexts and thus has become meaningless (Tannahil, 1985, Tones and Tilford, 2001). Likewise, Bunton, (1995) argues that health promotion has been something of a "hurrah" term that is easy to apply but hard to do anything about. For example, health promotion is often seen from marketing perspectives (Tones, 2001). This is related to misunderstanding the concept of "promotion" as selling as opposed to enhancing positive health and empowering individuals. This view underestimates the complexity of determinants of health at which health promotion operates (Ewles and Simnett, 2004). Previously cited authors argue that

health promotion is an umbrella concept including health education, preventative health and health public policy (Ewles and Simnett, 2004). Therefore health promotion, whether it is a discipline in its own right or an umbrella covering the activities of a wide range of disciplines committed to cover the health of the population. Nevertheless the problem emerges when health promotion and health education are interchangeably used among nurses (Maidwell, 1996, Fuber, 2000) as well as authors (Latter, 1998, Carroll et al, 2007). For the aim of this work however, they are considered not to be.

3.3 Health Promotion or Health Education

Health promotion and health education will not be treated as two faces of the same coin in this thesis. This would create problems in analysing its data and adds further confusion around what constitutes what. Whilst there is no agreement about what health promotion is (MacDonald, 2000, Tones and Green, 2004), it might be better to identify those features associated with health promotion and health education and how they relate to each other.

It is argued that the major elements of health promotion include socio-political roles, participation in public health policy formulation, social education programme development and political advocacy (Whitehead, 2003). These elements are needed to create socio-economic and political conditions that seek to promote health inducement rather than social injustice (Tones and Tilford, 2001). In other words, health promotion is more concerned about those less privileged in the society and thus political advocacy is needed as a mediation tool for influencing health public policies reform (Norton, 1998, Seedhouse, 2004).

In line with this argument, it can be suggested further that health care providers like hospital nurses who take up such a role in policy reform are likely to affect its development, modification and implementation. As Tones and Tilford (2001) demonstrate that political advocacy as a particular type of lobbying aims at representing underprivileged sections (e.g. homeless) in society and helps them to readdress power imbalance between them and other groups (e.g. educated and

uneducated people). The reality however is not the case. The health divide between the richest and poorest in the society is a manifestation of this failure (Lavis and Sullivan, 2000). To address structural determinants of health, health policy as part of health promotion needs to operate at both local and governmental levels through networking and continued communication between different groups in the society (e.g nurses, decision makers and lay people). Health education and related economic and environmental support for behavioural conducive to health needs to be integrated into the process (Stuifbergen, et al 2000, Resnick, 2003). On this basis, health promotions work is a deliberate and planned move away from an individualised responsibility and blame approach towards a wide reaching work encapsulating political and economical action. That is, it is a vehicle aimed at the process of reforming the social structure and policies that contribute to illness in communities. The importance of these overlapping elements are consistent with evidence indicating that a top-down, epidemiologically, driven approach often fails to achieve that (MacDonald, 2000).

On the other hand, health education is a communication activity that enhances health prevention and eliminates ill health by attempting to change unhealthy lifestyle practices of individuals (Tones and Tilford, 2001). Consequently, it is a component of health promotion itself. However, the above approach is likely to isolate individuals from their social and economic environment. It seems that, whilst health education might be essential for individuals to change their behaviour, it fails to address structural issues pertinent to health. This might not only minimise the impact of health education but it is also unethical as it charges individuals as victims of their unhealthy behaviours. Yet, as explored in this chapter, hospital nurses' role in health promotion is within the framework of health education (McBride, 1994, Cross, 2005, Casey, 2007).

A further comparison between health promotion and health education is offered by Whitehead's work (2004,a) but raises some concerns (see below). He analyses the concept of health promotion and health education in nursing. Whitehead (2004, a) used Morse's (2000) method of conceptual analysis based on the appraisal of the literature of health promotion and health education in order to explore the "pragmatic

utility of concepts”. The analysis was carried out to identify the level of “conceptual maturity”. If the conceptual contained clearly delineated and defined characteristics or preconditions, it was deemed to be mature. The results of this analysis found that health education is consistent between generic and nursing related sources. By contrast, health promotion with the increasing of its social and political literature and has become more complex and still evolving. In this context, Whitehead, (2004 a), concludes that health promotion has changed whereas health education is still “relatively” unchanged. Thus, according to Whitehead, (2004, a) the socio-political action has undertaken the individualistic approach of health education. The analysis offers valuable insights into the development of both concepts over the years. Its findings however should not be taken for granted.

The theoretical basis of the analysis was largely informed by nursing literature as opposed to the international debate in this area. For example, how the concepts would fit in with the movement of health promoting hospitals (see below)? In this context, what criteria do you need to examine whether health promotion or education is a mature concept? Indeed, as no an independent researcher was involved in identifying the degree of conceptual maturity, analysis bias cannot be ruled out. Perhaps the most surprising finding of this analysis is the claim suggesting that the literature on health education remains relatively unchanged over the last decade. This does not sit well with the argument indicating that health promoters need to clearly acknowledge the growing theoretical evidence of health education (MacDonald, 2000) and the use of empowering communication approach. Thus, whilst the analysis is a step forward in illuminating the meaning of health promotion and health education, its robustness is threatened by the above gaps.

Ewles and Simnett, (2004) take a different perspective in analysing health promotion and health education. They identified five distinct approaches to health related work. This includes, medical, prevention, educational, empowerment and socio-political. In current literature it has been argued that medical and prevention sit well with the health education paradigm (Tones and Tilford, 2001). By contrast, empowerment and socio-political approach are linked to the health promotion paradigm (Caelli et al,

2003). On this basis, it seems that certain health related approaches fit in with different health promotion and education paradigms. Medical and prevention models guide health education whereas, when the activities are politically driven, they are deemed as health promotion. Whilst the above analysis might aid the categorisation of nurses' practice in health promotion, it is rather oversimplifying the situation and might add confusion rather than clarity. For example, where would an educational approach fit in with the category? What would happen if nurses use a mixture of approaches to target the same problem? Why is there a cutting edge between different approaches to health promotion at the time health should be viewed holistically? Likewise, it is not clear if there is a difference between the medical model and the prevention model of health.

The above categorisation assumes that health promotion work has a unilateral dimension instead of overlapping issues involved. Yet it is argued that educational approach might serve as facilitating an individualised approach as well as empowerment processes (Seedhouse, 2004). Thus the gap between two paradigms (health promotion and health education) might be bridged. This however, left the educational approach "in the middle". It is not clear how to judge if the health educational approach is the link between two paradigms or a paradigm in its own right (Whitehead, 2004 a). It has been suggested that the degree to which the educational approach sits more closely with these paradigms depends on the degree to which its structure might facilitate an individual's enablement or community based empowerment (Tones and Green, 2004). It depends therefore on the complexity of its target and the level at which it operates, that is, a micro level (individualised approach) or macro level (community based approach). Nevertheless, individualised health education might be complementary but does not constitute the collective actions that underpin health promotion (Piper and Brown, 1998, Catford, 2005). Taking this argument further, social actions could enhance educational elements but this would not be successful without a radical political process. This is a crucial element of health promotion, as outlined above.

However, most nurses find themselves working within the framework of health education (Benson and Latter, 1998). It is on this basis that MacDonald, (2000) reminded us that there is a growing consensus that the traditional approach to health promotion, which is subjective of illness outcomes of medical paradigms are now considered to be unsuitable when applied to health care settings. This being said, it is argued that health education activities that are focusing on a health behavioural change approach are ineffective unless the outcomes are based on empowerment, collaboration and patient led strategies (Harm 2001, Caelli et al, 2003). Therefore an encounter that fosters self-worth is likely to result in positive health promotion outcomes. Yet regardless of the differences between health promotion and health education, there is a need to explain individuals' behaviours in order to meet their health needs (Downie, et al, 1991, Niven, 2000).

3.4 Health Promotion Theories and Models

There are a number of theories proposed in the literature that attempt to guide the work of health promotion as well as health education. Their features are examined in this section together with related weaknesses and their implications for hospital nurses' role in health promotion. Although no one theory is sufficient to fully explain health promotion behaviours, practitioners need to understand their implications for practice (Naidoo and Wills, 2000). Behavioural change theories are examined first because hospital nurses' roles in health promotion is guided by their ideologies as explored in this chapter (Maidwell, 1996, Furber, 2002, Cross, 2005, Casey, 2007).

Models of health related behavioural change are often derived from socio-psychology (Cole, 1995). This field examined the link between effective health promotion interventions and the social influence process (Mittelmark, 1999). Socio-cognitive or "social learning" theory was used as a means to explain health behaviours and to focus on the social context of behavioural change and its underlying cognitive process (MacDonald, 2000). Thus, it is driven by the notion that behaviour is guided by expected consequences. It indicates that health related behaviours are a result of the interaction between patients' beliefs and environmental elements (e.g. lung problems and pollution) (Tones and Green, 2004). Despite this,

however, socio-cognitive theories are based on a preventive health framework and thus sit more comfortably with traditionally defined health education as opposed to a wider reaching health promotion ideology operating at social and economic levels (Clark, 1998, Cullen, 2002). Therefore, these theories attempt to examine patients' reactions to the threat of illnesses and thus seek actions to minimise or eliminate this threat through health education. However, changing individuals' behaviour is a problematic and complex task. Not only might it lead to victim blaming but also to "cognitive dissonance" (Festinger, 1958). This is based on the concept that when clients face a situation when the delivered health education message is in conflict with their current beliefs and attitudes, they react in a manner that could create dissonance (e.g the belief that smoking would reduce stress) (Festinger, 1958). The theory contradicts to some extent the rational empirical theory that assumes that clients will make rational decisions based on view of information given to them (Baird, 1998).

Taking these points together, it seems that using the health information approach by nurses does not necessarily lead to rationalised decisions due to the complexity of the change process. In line with this, it is argued (Cole, 1995) that some individuals might not accept the advice even with convincing evidence that their behaviours are harmful to their health. Clark, (1998) goes further to postulate that the rationality should be reviewed as a motivated state because patients are likely to seek other ways to reduce tension and discomfort within their existing behaviour. In light of this it can be argued that individuals might adhere to their own agendas and continue with damaging health behaviours with or without a health professional's advice.

It would be naïve to expect individuals to change their behaviours due to the exposure to the scenario of the threat of illness and benefits of health (Whitehead, 2001). Other scholars have illustrated this argument further. It is proposed that individuals are often inconsistent in the way they approach health and thus there are many variations, which might occur in the encounter (Ogden, et al 2002). It is even more difficult therefore to ensure that health promoting behaviours continue over time. All above arguments might propose that the information-giving approach and

the fear of illnesses might not result in changing individuals' poor health practice. This highlights the limitations of health education as opposed to empowering based health promotion as discussed in the next section.

The opposite side of "cognitive dissonance" is the attribution theory (Abramson et al, 1978). It demonstrates that the individual might feel that they have no control over an unpleasant experience of illness and this might lead to passivity, cognitive deficit and helplessness. The issue therefore is not whether to resist health education, but that individuals might feel they have no control over their own health status.

Although the above theories are ideologically different, they link together health related actions, individuals' beliefs and indeed their agendas. The most developed models and theories in health promotion are based on psychosocial theories and are threatened by their limitations. The theory of reasoned action (Ajzen and Fisherbein, 1980) indicates that intentions to perform an action are determined by the individuals' attitudes towards the behaviour and the social norm. Thus, their beliefs are predictors of intentions that, in turn, predicts actual behaviour. Likewise, Pender's (1987) health promotion model explains the link between individuals' beliefs and their behaviours but fails to consider the impact of socioeconomic issues. Instead the model "views the environment as it relates to behaviour rather than how it relates to health"(King, 1994, p.214).

On the other hand, the health belief model (Becker, 1974), is largely guided by a preventive health approach as opposed to socio-economic and political approach to positive health. More recent socio-cognitive models did not give indications on how they might be operationalised in practice (Niven, 2000, Stuifbergen et al, 2000) or were too complex to use especially in a limited resourced setting (Whitehead, 2001a). The last two models have not yet been validated and thus their effectiveness is questioned.

However, although they are terminologically different (planning or evaluating models), they share similarities. That is, they attempt to establish the link between

the individual's knowledge, attitudes and beliefs and other theories about self-attribution and self-evaluation in order to explain these relationships (Tones and Tilford, 2001). It is not surprising that these models are not more than descriptions of how a process might work rather than how something does work (Curtis, 2000) and thus they do not offer solutions by themselves (Whitehead, 2004). On this basis, such models and their theoretical foundation should be approached carefully and not seen as a panacea for poor health education techniques (Cole, 1995). The author goes on to argue that such theories are time-consuming, esoteric, and out of touch modes of health care provision (Cole, 1995).

Yet this is over criticizing of socio-cognitive theories and their models and the above argument can be challenged. In fact, hospital nurses need to use them in explaining certain behavioural scenarios (Tones, 2001) and how individuals' beliefs and knowledge might interplay with lifestyle changes (Niven, 2000). Whitehead (2003), contends that nurses are aware of their limited role in health promotion as manifested by the lack of implementation of broad ranging health promotion actions. On this basis, other scholars (Latter 1998, Whitehead, 2000, 2001, Tones and Green, 2004, Cross, 2005, Irvine, 2007) argue that if the ideal is to be embraced by nursing, then it needs to be used in theory generation, research and education so it could be translated into practice.

However, the process is not as easy as it might appear. Adopting such theories and models when they are used in isolation from a suitable setting and context could lead to a reinforcement of a traditional health education paradigm (Piper and Brown, 1998). It is not surprising therefore that Nutbeam (1999) argues that in order to deliver effective health promotion, one must develop a framework that suits a certain health care setting and underpinned by a relevant theoretical constructs. This thesis responds to this argument by constructively developing a conceptual model for hospital nurses' role in health promotion within the Jordanian context.

To summarise, whilst the models and theories of health promotion have their own limitations (see above), hospital nurses need to incorporate recent principles of

health promotion into their ideologies. These theories are useful as long as they are seen to facilitate client power and choice and not led by a medical and authoritative approach (Piper and Brown, 1998). Specifically, socio-cognitive theories might offer valuable insights into the motivation, forces and constraints that could affect patients' behaviours and assist nurses to plan appropriate interventions (Whitehead, 2004 a), facilitate evaluation (Tones and Green, 2004) and inform the analysis of data emerging from this work. They shape therefore a theoretical framework against which empowerment based health promotion is compared and contrasted in the next section.

3.5 Empowering Model to Health Promotion

In recent years, empowerment model or approach to health promotion has become the focus of the international health promotion literature (Mackintosh, 1995, Mok and Au-Yeung, 2001, Houston and Cowley, 2002, Seehouse, 2004) and particularly has become a popular nursing topic (Webster and French, 2002). Whilst the behavioural and medical models are guided by the naive assumption that a medical information giving approach would result in changing individuals' behaviours towards health. On the other hand, empowerment model is more concerned about the complexity included in promoting positive health. This is in line with the broader health promotion agendas operating at socio-economic and political levels (Tones and Tilford, 2001). In light of this, this alternative approach has superiority over those previous medical and behavioural change approaches to health related work. The soundness of this argument is elaborated and examined below in relation to the potential of hospital nurses' role in health promotion.

The empowerment model is concerned about self-efficacy. It is the extent to which individuals believe that they can be involved in achieving a health promoting behaviours (Ewles and Simnett, 2004). Accordingly, the higher the individuals perceive self-efficacy, they are more likely to achieve the desired outcome (e.g. not smoking). The implication therefore for hospital nurses is to foster the beliefs in self-efficacy that might lead to making an informed decision. However, the capacity to make decisions is influenced by the self-esteem (Randle, 2003). Enhancing self-

esteem (high ranking of self-value) is an important element of the self-empowering approach to health promotion. This is because it might lead to the notion of looking after oneself (Berndt and Burgy, 1996).

Those with higher self-esteem are more likely to be able to resist social pressure and not conform to unhealthy lifestyle practice and are better able to deal with stress related to anxiety created to health threat (Grace, 1991, Callaghan, 1999). On this ground, it can be argued that when health care providers like hospital nurses are able to foster self-efficacy and self-esteem of their patients, this might lead to the adaptation of health promoting lifestyle practices. The self-empowerment model therefore is concerned with more than physical health. It considers the mental and internal complexity involved.

However, empowering approach does not only foster self-efficacy and self-esteem but also the interaction derived by the partnership approach as opposed to an expert led and top down approach of communication (Whitehead, 2004). This involves an active learning process and a two-way communication between health promoters and individuals. Likewise, in order to clarify values and beliefs of individuals, dialogue rather than prescription is needed to neutralise the power between them (McQueen, 2000, Canter, 2001).

A further major feature of empowerment model is related to the considerations of structural determinants of health. Empowering involves protecting the “host” (patients) from outside “agents” such as health inequalities by arming them with knowledge and social skills to deal with such agents (Piper and Brown, 1998). This can be achieved by policy development and offering them an access to health services such as counselling.

Bringing the features of the empowerment model together, it can be argued that nurses need not only to create a health promoting environment that maximize the capabilities of individuals for health related actions but also to contribute to the

development of healthy public policy. Within this context, empowerment has two interrelated dimensions of relevance to nurses' role in health promotion.

Whilst empowering individuals could mobilise communities, an empowered community which generates norms and support systems that enables individuals to acquire competencies and self-empowerment (Tengland, 2006, 2007). Having stated this, it can be argued that empowering hospital patients is the first step on the ladder of empowering the whole local community. So doing contradicts behavioural change and medically driven approaches, which are technically limited in their capacity to enhance positive health focusing on the personality growth and dependency.

Nevertheless, the above discussion should not be interpreted as behavioural change approaches having no place in health promotion and particularly in nursing. Of course, as discussed earlier, they might help in explaining why certain people adopt unhealthy lifestyle practices. What is advocated here is that empowerment approach to health promotion is ethically justified and is more effective than the former models due to the considerations of external (e.g socioeconomic) and internal factors (e.g self-esteem) interfering with health gain.

However, when it comes to nurses' health promotion work, all models need to complement each other given the complexity of such multidimensional work. Whilst the medical model of health has been discredited (Latter, 1998, Bunton and Macdonald, 2002), others argue that prevention and disease management is worthwhile in health promotion (Tones, 2001, Robertson, 2001). Likewise, it was found that features of empowerment models maximise the impact of preventative measures (Tones and Green, 2004). Therefore, integration of different models of health promotion is better than separating them. Whilst it has been advocated in this section because of its importance to hospital nurses' role in health promotion, the empowerment model of health promotion is not free of limitations.

3.5.1 Limitations of the Empowerment Model

Whilst medical and behavioural change models of health promotion marginalise socio-economic and political determinants of health, the empowerment model of health promotion is advocated both on grounds of ideology soundness as well as practical effectiveness (See above). It suffers however from some shortcomings and has been a subject of criticism. For example, it is argued that empowerment is still a “fashionable” concept and is disguised by the lack of clarity of its components (Tones and Green, 2004). Likewise, other writers extend this argument further by proposing that many practitioners do not like the term ‘empowerment’ as it is vague and has no clear meaning in the health context (Houston and Cowley, 2002). This concern echoes those expressed earlier by Brown and Piper (1995) arguing that empowerment is interpreted in a way that makes it with no clear purpose. Surprisingly, Grace (1991) is more critical of this and argues that empowerment disguises the background role of the external agent possessing the real control over individuals to make informed choices (Grace, 1991).

However, the background of these criticisms is threatened by a cluster of arguments. In fact, empowerment in health promotion is concerned with empowering citizens to take control of their health through mechanisms such as community development and formulating integrated health strategies (Webster and French, 2002). Indeed, whilst empowerment like health promotion is difficult to define, there is some agreement about its features such as participation and fostering self-esteem and self-efficacy as outlined in the previous section. More specifically, Normandale, (2001) defined what constitutes to the empowerment model. Normandale, (2001) argues that empowerment involves three aspects: “feel valued”, to be able take part in decision making and enabling individuals to make their own choices within the process of consideration of structural determinants of health (Normandale, 2001). It is not surprising therefore that empowerment is a “Holy Grail” in health promotion (Rissell, 1994), and the most important element of its ideology (Tones, 2001) as well as a key analytical tool in this work.

In summary, whilst it has been a subject of criticism, the empowerment model represents a more holistic approach to health promotion and has implications for hospital nurses. Ethically it is more justifiable and, practically, is more effective than the behavioural change approaches (Naidoo and Wills, 2000). The delivery of care by nurses often involves interaction with patients and their families and thus the utilisation of an empowerment approach which pays attention to the social and structural context for the individual is fundamental

This might involve two elements: the facilitation of the process of individuals' growth and development and a commitment to challenge health inequality. Therefore, as argued by Tengland (2006) empowerment is not only a legitimate goal for health promotion but also a process involving participants in problem formulation, decision-making and actions. Before examining nurses' roles in health promotion in general, it might be useful to first explore and debate the health promoting hospital movement. This is an important issue given the study's hospital setting focus.

3.6 Health Promoting Hospitals: Implications For Hospital Nurses

In the mid 1980s the Ottawa Charter (WHO, 1986) led the development of a health promoting-setting approach. This includes schools, workplaces and hospitals. More recently, attention was given to health promoting universities (Beattie, 2002) and health promoting prisons (Watson et al, 2004). Although these settings are overlapping when it comes to wide-reaching health promotion work, for the purpose of this thesis, the focus will be only on health promoting hospitals. Five action areas for health promotion were identified by the Ottawa charter and given in the following box to inform the analysis of this study.

Box 1: Ottawa Charter (WHO, 1986) actions for health promotion

1. Building healthy public policy - health promotion policy combines diverse but complementary approaches, including legislation, fiscal measures and organisational change.
2. Creating supportive environments - the protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.
3. Strengthening community action - community development draws on existing human and material resources to enhance self-help and social support, and to develop flexible systems for strengthening public participation in, and direction of, health matters.
4. Developing personal skills through information and education skills - enabling people to learn (throughout life) to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential.
5. Re-orientating health care services toward prevention of illness and promotion of health - the role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services.

Whilst the above actions represent a comprehensive strategy for health promotion ranging from individual responsibility to re-orientating health services towards its vision, it should be noted that a hospital as the setting for this study, is not only about the physical environment and policies. Instead, it is:

“where people actively use and shape the environment and thus create or solve problems relating to health ...it includes physical boundaries and a range of people with defined roles and an organisational structure (WHO, 1998 P:3).

It is therefore not only where people carry out clinical tasks. The above definition, however, simplifies health promotion work as it separates the hospital from the surrounding environment. In line with this, it was warned by Green et al, (2000) that the setting is beyond carrying out certain health related goals within the organization. They argued that the setting is culturally constructed and is “the medium and the product of human social interactions” (Green et al, 2000, p23). This broader understanding of the setting sits comfortably with Kleinman’s (1978) model of the medical health system as a cultural system. Accordingly, it can be argued that the setting is the interaction between individuals in the organization and the existing cultural structure. This understanding will be used throughout this thesis and when the word “setting” is used.

The features of health promoting hospital movement together with related problems are illustrated below. The health promoting hospital movement was supported by many charters, declarations and conferences. This included the Budapest declarations (WHO, 1991), the Vienna recommendations (WHO 1997) and the Austrian conference which urged the implementations and evaluation that has been launched previously (WHO, 2007). These recommendations are given in Box (2).

Box 2: Vienna recommendations (WHO 1997) for health promoting hospitals

- Focusing on services that contribute to the empowerment of patients and holistic care..
- Formulating close links with other levels of health care systems and community.
- Fostering commitment through encouraging participatory, and -gain-oriented procedures that involve all professional groups and build alliances with professional outside the hospital setting.
- Encouraging participatory roles for patients according to their and potential and improving patients' well-being.
- Improving the hospital’s communication and cooperation with social health services in the surrounding community and optimize links between different providers, users and actors in the health care sector.

In light of these recommendations, it can be argued that the health care organisation is obligated to a radical reform of health service away from the individualistic and medically oriented service to a more empowering and wide reaching service (Whitehead, 2004a, 2005). Therefore, health promoting hospitals urge the development that is guided by principles of modern health promotion outlined in previous sections.

The importance of the hospital as a setting, in general for health promotion, and in particular to hospital nurses, is reinforced by a number of arguments. Although hospitalisation time might be stressful for patients, it often acts as a catalyst for change and increases patients' motivation to gain more information about their illness and how to cope with it in the future (McBride, 1995, Ewles and Simnett, 2004). Likewise, hospitals are seen as credible sources of advice and health issues beyond their responsibilities for sick people (Aiello et al, 1996) and their medical staff are well respected in many societies (Johnson and Baum, 2001).

Environmentally speaking, hospitals produce a large amount of hazardous clinical waste and dealing with it by health promotion interventions might contribute to a safe conducive environment for health (Groene and Garcia-Barbero, 2005). Taking these arguments together with the principles of the health promoting hospitals movement (see above), it can be argued that hospital nurses need not only to offer high quality curative services but also to integrate health promotion through organizational change and social structure. Thus, on this basis, the hospital needs to support active participation of patients and staff and builds a supportive hospital environment and links it with the local community.

Specifically, if nurses need to play an important role in health promotion, they need to embrace the radical health promotion reform (Whitehead, 2005). It is debated that health promotion hospitals need to use an episode of illness as an opportunity to promote health through providing rehabilitation service and empowering patients to use the necessary health care services (Tones and Green, 2004). Thus, it acts as an agent to use a community base approach for health by networking with local national governmental and non-governmental agencies. Against this backdrop however,

hospital nurses' role in health promotion operates at individualised and educational levels and thus the suitability of hospitals for health promotion is marginalised (McBride, 2004, Cross, 2005, Irvine, 2007). This is fully discussed in the second half of this chapter.

Although the health promoting hospitals movement might be used to produce a more radical health promotion work, there are some issues worth consideration. It is recognized that some principles of health promoting hospitals are of relevance to any health care system (e.g. holistic health approach). The WHO however has focused almost exclusively on the development of this movement in the high income countries (e.g. Germany and France).

These recommendations might not be more than "buzz principles" in low income countries as the case with the current Jordanian study. This is due to the lack of financial resources and trained staff. These barriers to health promoting hospitals have already been identified even in high income countries (Auamkul et al, 2003). However, the way of addressing the lack of financial resources within the hospital sometimes might be detrimental to health promotion itself as illuminated below. In order to tackle the lack of funds in public hospitals where the largest sections of community are served, there is an increasing demand to reduce the length of patients' hospitalisation (Johnson and Baum, 2001). This may not only may affect curative services and recovery, but also is likely to minimize the importance of episodes of illness for any health promotion work (Gulimette et al, 2001).

To add to the problem, it is argued that the majority of hospital health professionals like nurses do not really associate health promotion in their practice (WHO, 2003). Other authors are more critical of this issue and argue that health care providers devote more time for clinical duties than health promotion or even at least basic health education (Cullen, 2002, Shu, 2004). It is therefore not surprising that: "there is a danger that the rhetoric of reform can be used while in practice the initiatives is doing little that is new and certainly not achieving the structural and organizational change" (Johnson and Baum, 2001, p, 286).

These arguments however are largely guided by theoretical base rather than empirical evidence. Consequently, there is a need for more research to examine how health providers like hospital nurses might contribute to the development of health promotion in such a setting, i.e. the gap between rhetoric and reality needs not only to be theoretically debated but also empirically examined. However, in order to use the hospital as a platform for promoting patients' health, the nature of nurses' roles in health promotion should be explained together with contributing factors.

3.7 Health Promotion as a Framework for Hospital Nurses

Over the last decade there are rallying calls in the literature urging nurses to play a key role in health promotion (Latter 1998, Whitehead, 2000, 2001, Tones and Green, 2004, Cross, 2005, Irvine, 2007, Whitehead et al, 2008). It has been proposed that nurses have the position to lead the new health promotion movement (WHO, 2003) and promote the health of individuals and communities (WHO, 2001). The importance of the development of hospital nurses' roles in health promotion is based on a cluster of arguments elaborated below. It has become clear that the vast majority of global nurses work in hospitals and thus they represent the biggest workforce in such settings (Whitehead, 2005). Nurses have close contacts with patients and their relatives creating a significant opportunity for delivering health promotion (Kelly and Abraham, 2007). Arguably, health promotion therefore is a prerequisite for high quality of care and the effectiveness of the interactions with patients. To this end, it can be argued that hospital nurses need to have skills to analyse health problems within the society by understanding the local community values and beliefs.

Therefore, nurses are unable to promote health and deliver holistic care unless they are aware of the structural and social determinants of health. This is validated by previous sections (see 3.3 and 3.4) revealing that health education alone is ineffective, ethically questioned and fails to address wider issues pertinent to health. The reality is that the aim of health promotion is widely political (Seedhouse, 2004). For example it needs to address the needs of less privileged groups in the society and eliminate inequalities. This suggests that a nurse's political role is needed to

complement their health education practice. Therefore, hospital nurses need to understand broader meanings of health promotion in order to achieve not only high quality of holistic care but also health inequities in the society. That is, the role of hospital nurses in health promotion is complex and multi-dimensional. It involves providing health information, promoting self-esteem by empowering individuals, encouraging decision making and changing physical and social relations.

Against the above backdrop however it is argued that nurse's roles in delivering health promotion was not being realised in hospitals (Casey, 2007, Kelly and Abraham, 2007). Likewise, hospital nurse's ability to implement effective health promotion activities have been questioned (Whitehead, 2003, Casey, 2007, Whitehead et al, 2008). It was found that socio-political health promotion are largely neglected by nurses and predominately adopts a medical and preventative method of health education activity (Casey, 2007, Kelly and Abraham, 2007). Whilst nursing and health promotion have at their core humanistic philosophy, the reality is that nurse's practice is shaped by the medical model (Whitehead, 2001). The net conclusions of these arguments suggest that hospital nurses adhere to health education related individualised issues as opposed to the modern health promotion, which has an empowerment base and is politically driven. Thus, it is argued that moving away from a limited medical model of disease prevention to health promotion is an appropriate way forward for nursing (Liimatainen et al, 2001). However, caution must be exercised against the above argument discrediting the prevention role of hospital nurses. Despite the increasing criticisms of medically guided health promotion work (Maidwell 1996, Irvine, 2007, Casey, 2007). Nursing interventions can bring about the situation whereby those activities under attack are accompanied by health promotion values such as empowerment and collaboration (Goel and McLsaac, 2000). In the same context, it is suggested (Harm, 2001) that the establishment of health promotion in curative services requires health professionals to integrate the framework of health promotion into the traditional medical model of health. Whilst this sounds a good idea, it is argued, however, that applying the health promotion concepts to traditional medical practice is practically difficult as doing so

might be “diffuse, all encompassing or even annoyingly esoteric” (Zapka, 2000, p242).

The above argument is challenged by Tones and Tilford (2001) who point out that health promotion and health education need to be integrated. Similarly, it is argued that health education might only be effective if supported by some elements of health promotion such as health public policy (Adam and Armstrong, 1996, Robinson and Elliot, 2000). Therefore, it can be argued that there is no reason why medically guided health education cannot go hand in hand with the principles of health promotion such as empowerment and political actions. In fact:

“..... the tension between [health promotion and health education] is both unhelpful and is known to have a profound effect on nursing activity” (Whitehead, 2003, p: 796).

Nevertheless, if nurses continue to work within the framework of the medical model of health, they might fail to be motivated politically and thus will tend not to collaborate with other agencies to address societal and environmental factors pertinent to health (Whitehead, 2000, Seedhouse, 2004). With the above discussion in mind, it seems that, whilst health education alone is ineffective and might lead to victim blaming, these gaps are bridged by the principles of health promotion such as partnership and the avoidance of the expert-led approach.

3.8 Factors Affecting the Development of Hospital Nurses’ Roles in health Promotion

A number of factors have been identified in the literature that interplays with nurses’ roles in health promotion. It is argued that nurses are often confused about health promotion and health education and they use them interchangeably (Whitehead, 2001). Research reveals that nurses’ understanding of health promotion aims at changing individuals’ lifestyles (Cross, 2005, Casey, 2007) as opposed to health promotion outlined earlier in this chapter. To add to the problem, there is a gap

between rhetoric and reality and nurses might be unsure about what is carried out in the name of health promotion (McDonald 2000, Seedhouse, 2004). That is, nurses may call themselves health promoters but in reality, they are health educators (Whitehead, 2004).

Moreover, the lack of time and resources might make it difficult to promote health, particularly in busy wards (Whitehead, 1999). This was confirmed by limited research (McBride, 1994, Cross, 2005). With these factors in mind, other scholars take a different stance (Caelli et al, 2003). They argue that if health promotion is to be established in busy hospital, nurses do not need “in-depth” theoretical knowledge in health promotion in order to translate it into practice (Caelli et al, p. 173, 2003).

This is, however, does not sit well with health promotion principles advocating the delivery of wide-reaching politically driven activities. Indeed, it is not clear what “in-depth theoretical knowledge” means and whether it is related to health education or empowerment approach to health promotion. Therefore, Caelli et al’s (2003) argument is not only vague but, more importantly, inconsistent with modern health promotion. Perhaps, health promotion should not be seen as an added activity but rather as an integrated element of any interactions with patients (See Empowerment Approach). Thus, nurses are urged to develop more in-depth knowledge and skills in health promotion and thus Calli et al’s argument is discredited in this thesis.

A further factor that might contribute to hospital nurses’ roles in health promotion is related to the nature of health promotion education. Individualistic health education ideology was found within the framework of nursing education which prepares students as role models of healthy behaviours whilst structural factors are likely to be ignored (Whitehead, 2002). The wider political and economic aspects of this health promotion are often absent in the education of nurses/ nursing curricula(Rush, 1997).

On this basis, it is little wonder that patients might be blamed for not adhering to health promoting behaviour. Therefore, without recognizing the responsibility located at the socio-political levels, nursing students might be socialized with role

modelling focusing exclusively on preventing illness through an authoritative approach as opposed to empowering health promotion (Grace, 19991, Tones and Green, 2004).

Likewise, it is argued that health promotion needs not only to be clearly integrated into the curriculum of nursing students (Naidoo and Wills, 1998), but the underlying philosophy of nursing needs to express *both* a notion of active nursing for health *as well as* care in the context of disease (Smith et al, 1999).

That is, if students are exposed only to behavioural change components and are not sensitized to structural realities, it will not be surprising that their future role in health promotion is confined to an individualised and potentially victim blaming approach to health promotion. Whilst it is argued that students' conceptualisations of health promotion have an impact on their future role as health promoters, earlier work has yielded rather contradictory evidence. On one hand, it was found that their understanding of health promotion is largely informed by traditional and victimizing approaches that focus on changing lifestyle practices (Macleod Clark, 1998). On the other hand, evidence shows that Project 2000 educated nurses work with broader perception of health promotion operating at the level of empowerment, socio-economic factors and policy formulation (McDonald, 1998). Although these studies need to be replicated to verify their findings, the latter study indicates that education that is more effective is likely to broaden nursing students' understanding of health promotion. However, the extent to which education might foster or inhibit hospital nurses' role in health promotion is still a largely unexplored area in general and particularly in Jordan.

There is a paucity of data to examine the extent to which education might affect hospital nurses' role in health promotion in real practice. Thus, it seems it is important to examine the link between the nature of health promotion education and its impact on the development of nurses' role in health promotion. This is an important issue as past and recent evidence indicate that within the clinical learning environment there is a shortage of new role models in health promotion (Smith et al,

1995b, Schickler et al 2002) and a limited integration of theory and practice of its principles such as empowerment and political actions (Smith et al, 1999, Cross, 2005, Casey, 2007).

In addition to above factors, patients' reluctance to get involved in health promotion work as well as unsupportive management at hospital level, were reported in the literature (McBride, 1995, Irvine, 2007). This might be linked to nurses' social status. Whilst it is acknowledged that nurses have developed a responsible caring role, the social image of nurses in general is being submissive to a doctor (Hallam, 1998, Tang et al, 1999) and thus nursing was seen as a low status profession (Seago et al, 2006). In view of this, patients might not be receptive to hospital nurses' role in health promotion. However, to date, these factors are largely generated as a result of theoretical debate rather than empirical investigations. Research carried out in this area is still limited and suffers from significant limitations as fully explained in this chapter (McBride, 1995, Cross, 2005, Casey, 2007). In consequence, there is a need for more studies in this area to verify such factors in general and their applicability to the Jordanian education and health care system.

3.9 Summary of the Meaning of Health Promotion within Nursing

This chapter sheds light on the ideology of health promotion and related theories. Health promoting hospital movement, together with the importance of hospital nurses' roles in health promotion with contributing factors involved, have been outlined. The review of the literature indicates that whilst there is no one definition of health promotion, there is some agreement on its features which have implications for hospital nurses' practice. This involves health education, health policy and empowerment. These elements need to be underlined by holism of health, equity, participation, collaboration and partnership. Taking them together rather than separately might maximise the impact of health promotion and avoid victim blaming approach associated with individualistic health education and authoritative communication approach. That is, nurses' actions would only be seen as health promoting and empowering if it was patient-centred rather than authoritative and was open to active listening (Caelli et. al, 2003).

The chapter argues that hospital nurses need not only to be aware of broader meanings of health promotion but also translate this in practice. The reality is that ill health in society is socially, economically and culturally constructed (Whithead, 2003, Seedhouse, 2004). Therefore improving the health status of populations is often outside an individuals' control and requires social and political action. Health professionals need to focus on "environmental engineering" that seeks to achieve social change, through the encouragement of economic, fiscal, social change and political reform (Norton, 1998, Naidoo and Wills, 2000).

There is therefore a need for hospital nurses to take a more political role in order not only to promote health gain in the hospital and wider community but also to familiarise themselves with politics and nursing and thus the decision making process. The extent to which these values of health promotion have been addressed by empirical work is the focus of the following section. This is an important issue as there is no universal agreement on what health promotion is and thus there are wide perceptions among nurses about what constitutes its meaning and how it is practiced (McDonald, 1998, Cross, 2005)

3.10 Previous Studies on Hospital Nurses' Roles in Health Promotion

Given the extensive research in general in health promotion area, the search of the literature was narrowed down to specifically focus on the study aims and its hospital setting focus. The reviewed literature has identified a limited international studies examining hospital nurses' role in health promotion. The deductive analysis of these studies reveals that they are small scale research and largely carried out in the UK (see below). Although some researchers (McBride, 1994, Cross, 2005, Casey, 2007, Carroll et al, (2007) claim that they focused on health promotion, the theoretical framework, together with the development of methods used, addresses health education related issues as opposed to the health promotion outlined in this chapter. In order to offer an inductive analysis together with critique of the available studies, it was decided to categorise them into three categories. The first category presents all

the available international studies. By contrast, the second category deals specifically with Jordanian studies. The third category involves studies that focused on patients' understanding of health promotion and related experiences. The review starts relative to the time when the study was undertaken, that is, from the oldest to the most recent. This would enable comparisons to be made and identify areas that have not yet been fully researched. Then conclusions of all previous studies are offered, the gaps in the existing knowledge are identified and the need for the current research is highlighted.

3.10.1 International Studies on Hospital Nurses' Roles in Health Promotion

Whilst it is more than a decade old, McBride's work (1994) is frequently cited in the literature and is of relevance to the aim and methodology of this study. McBride (1994) has looked at hospital nurses' attitudes and beliefs towards health promotion using a postal questionnaire involving 296 hospital nurses in acute wards in England. From the total posted questionnaires (n=296), 225 were returned giving a response rate of 76% . A four point Likert scale was used to measure their attitudes towards health promotion. It was found that a total number of 95% (n=214) felt that they should be health advocates and that health promotion needs to be put on the political agenda. About 81% (n=180) of nurses believed that health education is not guilt inducing and victim blaming. The lack of training, time and resources were cited as barriers for their role in health promotion. McBride (1994) argues that, whilst there is no a specific strategy for health promotion within the acute settings, hospital nurses "felt professionally responsible to take such a role [in health promotion] in their practice" (p: 99). However, although the findings are promising, it is difficult to examine their credibility. This is due to the lack of information about the research process. Although McBride (1994) reported that the questionnaires were given out t to all nurses in acute wards, the number of nurses was not mentioned. Thus, it is not possible to asses whether the response rate was satisfactory or not.

On this basis, the generalisation of the findings is debatable. Indeed, the validity and reliability of the questionnaire cannot be assessed as no copy was offered. However, items reported in the article (p: 95) suggest that the study has a low internal validity.

All the items led respondents to express positive attitudes towards hospital nurses' involvement in health promotion. This includes: "Nurses are more appropriate people than doctors to get involved in health promotion" and,

"Hospital nurses are ideally placed to give health education to patient".

It is not clear if these items were balanced with equal numbers of negatives statements towards health promotion and distributed randomly in the content of the questionnaire. Doing so might reduce the socially desirable responses. The reliability of the questionnaire might also be in doubt. Two items presented on pages 95 and 98 are flawed as each includes two or more than one item:

"Hospital nurses should interfere with people's lives by telling them to stop smoking, lose weight or take more exercise" (p:95) and

"Nurses can change people's lifestyles despite cultural and environmental influences". (p:98).

For example, the latter item puts the respondents in a dilemma. They might think that it is true of cultural influences but not of the environmental influences or vice versa which leads to unreliable responses. Finally, whilst the study offers an overall picture of nurses' attitudes towards health promotion, its findings are superficial and did not expose complex issues (McBride, 1994). This might be explained by the pre-formulated structured items used which constrained the emergence of complex responses.

Moreover, the above positive findings are self-reported and the extent to which they are translated in practice is questioned. It seems therefore that a more recent research using observation, together with qualitative methods is useful. In light of the increasing development in health promotion, the study, which is now, more than a decade old needs to be replicated to verify findings with different sample of hospital nurses and methods. Taking the above limitations as a whole it is difficult to draw

any credible conclusion about hospital nurses' attitudes towards health promotion from the McBride's study.

Using a mixture of quantitative and qualitative data collection methods, Davis (1995) investigated nurses' understanding of health education and health promotion within a neuro-rehabilitation setting. Semi-structured questionnaires (n=33) were distributed to two neuro-rehabilitation centres in England. The study has achieved a poor response rate 54%(n=18). In addition to the semi -structured questionnaire, three focus group discussions were conducted with two nurses from each centre. The researcher, who works in one of these centres, has facilitated the groups' discussions (Davis, 1995). The data were collected by asking the nurses to make notes on interview questions about their role in health promotion within neuro-rehabilitation centres. Both descriptive and content analyses were used to analyse the questionnaire and interview data. The findings showed that nurses have successfully identified their role as health promoters, but they were unable to distinguish between health education and health promotion. Given the mixture of methods used, it is expected that a more systematic account of nurses' understanding of health promotion might emerge in comparison to McBride's work. However, the study has focused only on one area of nursing practice and thus a comprehensive picture about hospital nurses' role in health promotion cannot be drawn. Moreover, the number of nurses who completed the questionnaire was small (n=18) and, as a result, the study failed to achieve statistically significant results. In addition, it should be noted that focus group sample size was indeed too small (n=2) to offer rich data through the dynamic action of the group. In fact, if the number of focus group participants is less than 4, it cannot be considered as a focus group discussion (Moragn, 1998). It could also be argued that the involvement of a researcher with a senior position in the focus group discussions could have restricted nurses from offering valid responses. This could have been avoided if an outside investigator has facilitated the focus group discussions instead of the author (Davis, 1995). The study focused on an important area of nurses' practice. However, its findings are compromised by its small scale, the lack of observation of actual practice and has not been replicated to verify its findings. Whilst Davis, (1995) has focused mainly on neuro-rehabilitation settings,

Maidwell's (1996) study looked at the role of the surgical nurse in general as health promoters. The author attempted to test the null hypothesis, which states that "hospital nurses do not have a role as health promoters within surgical settings" (Maidwell, 1996, P: 899). A semi-structured questionnaire was developed which included relevant questions regarding health promotion in surgical settings, particularly about its definition. The executive nurses as well as the surgical ward managers helped the author to choose the sample and to distribute the study's questionnaires. Out of the 68 questionnaires were given, 52 were returned to achieve a 76.6% response rate. The responses were transcribed by the author and the main themes were identified (Maidwell, 1995). The responses indicated that surgical nurses are encouraging patients to participate in care and health lifestyle advice. The respondents defined health promotion as preventing illness and curing disease. In a similar conclusion to McBride's study (1994). Maidwell, (1996) stated that,

"The study's results are encouraging for the development of more positive attitudes towards health promotion within surgical settings" (P:903).

The author went further to reject the null hypothesis and to state that surgical nurses have a role for promoting patients' health. However, no statistical evidence was given such as P value to confirm this. Given the small sample size of participants (n=52), it is not clear how a meaningful statistical significance was achieved. Although the involvement of ward managers in selecting the surgical nurses could have facilitated the study response rate (76.6%), it raises questions about a possible selection bias. It could be suggested that only surgical nurses who were interested in health promotion were chosen, but those who were not, were not involved in the study.

In light of this, the conclusions that author has drawn perhaps are not valid. Likewise, on page 903 it was stated that:

"patients and family education should be more structured, with learning needs being reviewed at certain times".

This call is largely based on the author's point of view as neither patients nor their families were involved in the study. This suggests that studies are needed to examine nurses' role in health promotion not only from their own perspective but also from the perspective of patients they look after. As a result, the gap between nurses' role in health promotion and patients' needs might be identified.

Furber, (2000) explored midwives' attitudes to health promotion by using a questionnaire. It was developed from extensive literature review about health promotion and from five exploratory semi-structured interviews with senior midwives from a range of clinical areas in the pilot hospital. The interviews were audio taped and then transcribed by Furber, (2000). The transcripts were "cut up" and placed together to facilitate identification of comparable themes to responses. Then the draft of the questionnaire was sent to the midwives who participated in the exploratory interviews and five other midwives who have research interest in health promotion. Furber, (2000) has examined the questionnaire's content validity by asking midwives (n=9) if the aims and objectives were met by questions. Following the return of the questionnaires, four respondents were asked to fill in another identical questionnaire to examine its reliability.

No reliability coefficient was given but Furber, (2000) stated that the majority of respondents' responses were identical. The questionnaire consisted of questions related to opinions, behaviours and beliefs towards health education and health promotion. It was posted to 182 midwives and 152 were returned to attain a 83.5% response rate. It was found that the information and client directed centred approach was the most favourite one for a total of 131(86%) of midwives.

About 84% (n= 128) believed that time availability was the most constraining elements for them to adapt their health promotion role where they work. As well, half of the respondents 50% (n=76) state that the lack of specific training in health promotion is a barrier to improving their health promotion role. The majority of respondents 84% (n=42) prefer to use leaflets to promote people health. The author concluded that midwives were predominantly working as health educators and

focusing on an individual-to-individual approach instead of a broader understanding of health promotion (Furber, 2000). Moreover, Furber, (2000) recommends that future research should be investigating midwives' role in health promotion using a qualitative approach

However, despite this, research has drawn some useful findings to develop midwives' training in promoting people's health, its robustness is threatened by a number of factors. First of all, like McBride's study (1994), it is surprising that Furber, (2000) was willing to examine nurses' attitudes towards health promotion without focusing first on their understanding of this concept, which might formulate their attitudes towards it. Moreover, it is not possible to assume that midwives' attitudes towards health promotion are consistent with the actual practice. Although using closed ended questions might have facilitated the questionnaire analysis, they do not offer respondents with an opportunity to expand their responses and therefore to provide richer data. The study focused on midwives' role in health promotion. Given the difference in the training and the nature of nursing practice, the applicability of these findings to surgical and medical nurses is questioned.

This was somewhat addressed by Cross (2005) who focused on nurses' attitudes towards health promotion at the Accident and Emergency (A&E) (Cross, 2005). As with many researchers in this field (e.g. McBride, 1994, Furber, 2000, Irvine, 2007) a single method was used to collect the data throughout a semi-structured questionnaire. In addition to the question about the meaning of health promotion, the questionnaire has included 33 statements representing according to the author, diverse attitudes towards health promotion (Cross, 2005). They were derived from the main arguments about health promotion in the literature. However, from the references list, it would appear that it is not the case. The references used were exclusively based on the nursing literature. Thus, the extent to which such statements reflect a wide range of issues and debate about health promotion is questioned. This lack of the systematic literature review during the development of the questionnaire is somewhat tangled with the author's argument (Cross, 2005) that:

“ An effective Q study depends on thorough sampling of the items [based on] careful and methodical review” (p:477).

However, whilst the validity as well as reliability of these statements is not apparent, the author stated that “three nurses” did comment on their appropriateness. All the statements (n=33) were backed up by a suitable reference from nursing. The questionnaire was distributed to a convenience sample of 141 A&E nurses in two English hospitals. Only 11 questionnaires were returned giving a very poor response rate (RR=7.6). No clear explanation for this poor response rate was given, but the study’s generalisation is negatively affected. Despite the difficulties, the study offers some important findings of relevance.

Although the exact number is not reported, the “majority” of the nurses had positive views towards health promotion. The most statements agreed with was that “nurses play a large part in educating people by using their knowledge and interpersonal skills to promote self care”. In contrast, nurses strongly disagreed with the statement that “admission to hospitals can act as catalyst change”. Also the results have found that the nurses’ understanding of health promotion has included a wider political and economic aspect of health promotion and not only illness related issues. However, the positive attitudes expressed by A&E nurses towards health promotion should be taken mindfully. This is not only due to the poor response rate but also due to the quality of the reported statements. The majority of the statements are positive as the case with McBride’s work (see above). This could illuminate the favourable findings emanating from both their studies.

Cross (2005) has frequently mentioned the importance of “communication between nurses and patient” and “nurses’ health promotion practice”. Because of the nature of the questionnaire, it would not be possible to thoroughly examine these issues. Thus, employing observations might be advantageous to capture the interaction between nurses and patients and identify the nature of the encounters between them (e.g. nurse led communication approach or partnership). Indeed as Cross (2005) has asserted:

“Further research is needed into nurses’ actual health promotion activity and their perceptions of barriers of effective health promotion” (p:481).

Accordingly, the above suggestions are incorporated in the current research’s objectives. In brief, the study by Cross (2005) is acknowledged as it is the only one which has focused specifically on A&E nurses’ attitudes towards health promotion. It offers some empirical knowledge about nurses’ understanding of health promotion in such a setting. However, in addition to the problems outlined above, the study has exclusively focused on A&E setting and thus the applicability of its findings to other nursing areas (e.g. acute and chronic wards) is in doubt. Indeed, whilst Cross (2005) highlighted the importance of A&E for health promotion, the appropriateness of such a setting can be debated. This is because such settings have important priorities for saving lives and the nature of the interactions between nurses and patients is different and often short (McKenna, 1994). In light of this, the setting itself might contributed to the poor response rate the study has achieved.

All the above suggests that the study made a limited contribution to the health promotion within the hospital setting in general and the picture about how it is practiced by nurses is still vague. That is, the need for a more comprehensive empirical work including hospital nurses and patients is evident.

A more recent but small-scale work by Casey (2007) has examined nurses’ perception and understanding of health promotion. A semi-structured interview with eight nurses in an acute ward was undertaken. The sample was selected purposely and data were analysed thematically. It was found that nurses’ descriptions of health promotion are in line with health education approach encapsulating individuals’ changing behaviour approach. The lack of time and “organisation and management issues” were found to affect nurses’ roles in health promotion. However, due to the purposely selected small sample size of nurses (n=8), the generalisation of such findings is not possible. The study has focused only on one acute ward and therefore the extents to which its conclusions are applicable to medical wards are open to

debate. This is an important point as surgical nurses are likely to deal with different cases than those in medical wards. Indeed, the study is small scale work and lacks an in-depth theoretical framework to systematically examine complex barriers outlined above. Related to this, theoretically the study was only guided by Ottawa's Charter (WHO, 1986) of health promotion. For examples, nurses' understanding of health promotion has not been discussed within the context of health promoting hospitals ideology. On this basis, the study's conclusions are threatened by a limited theoretical framework. It however highlights the need for more systematic research to illuminate what is referred to implicitly as "organization and management issues". The current thesis attempts to bring such issues to light using a much more complex method.

A further Welsh study by Irvine (2007) examined the link between district nurses' understanding of health promotion and their actual practice. Semi-structured interviews were undertaken with 21 district nurses. Nurses were asked how they understood health promotion and translated it into practice. Again, like Casey's work (2007), it was found that nurses' understanding of health promotion was confined to medical and educational behavioural change approaches. Irvine (2007) goes on to conclude that:

"...these interpretations were translated into practice, where district nurses adopted a mainly reactive and individualistic approach to health promotion" (p593).

The study offers interesting insights into how nurses promote health in relation to their experience. However, the conclusion should be approached carefully. It is not only confined by the small sample size of nurses (n=21) but also methodologically is flawed. This is because nurses' understanding of health promotion and actual practice has not been cross-checked by observational data. Simply, nurses' perceptions of what they do in the name of health promotion might not match the real practice as reported above. That is, there is a big difference between the awareness of health promotion and practising health promotion.

Therefore, the aim of the research “how [nurses] translate their understanding [of health promotion] into practice” (p.593) cannot be accurately achieved by self-reported experiences. The researcher goes further to make unwise claims by stating that:

“ ...[the study has produced rich data, highlighting issues that have important implications beyond the regional level”p(600).

Clearly, a sample of 21 nurses threatens the ground of such a claim and indeed simplifies the nature of the organisational culture. Taking these limitations together, it can be argued that, whilst the study is valued for its intention to uncover a largely unexplored area in health promotion, it is difficult to draw a firm conclusion about nurses’ role in health promotion in its broader meaning.

By utilizing a phenomenological approach, Whitehead et al (2008) examined the meaning of health promotion among nursing students and senior nurses at a Chinese hospital. A sample of 8 participants was selected purposively but no details were given about the number of participants from each group. In depth interviews were conducted by a senior nurse and a nurse educator at the hospital. Data were analysed thematically and shared with participants for validation. It was found that nurses were aware of the meaning of health promotion and health education but due, to the constraints such as the lack of resources and time, their practice was limited to health education. Some references were made by participants to the empowerment model of health promotion.

These findings are more positive than those reported earlier (Furber, 2000, Irvine, 2007, Casey, 2007) particularly in terms of understanding health promotion. However, the methodology of the study together with its conclusions is threatened by a number of factors. Selection and responses bias is likely to be high in this research. This is because the sample was selected and interviewed by senior colleagues working at the hospital. Given the possible hierarchical relationship, not only those motivated participants might be selected but also their responses could be idealised

to meet the expectations of senior colleagues. Again, as no observations were carried out, their actual health promotion can be debated. Finally, researchers concluded that: “Health promotion and health education are universal health related constructs. Thus there is an expectation that all nurses will implement these in a similar fashion” (Whitehead et al, 2008, p,181).

Whilst it is recognized that principles of health promotion share similarities worldwide, it is unwise to conclude that all nurses need to implement them in a similar way. Not only is such a claim unsupported by robust evidence given the small sample size, but also it is rather simplifying the implementation of health promotion in different settings. For example, by no means is the organisational climate alike for nurses worldwide when it comes to the implementation of health promotion. In many health care systems, there are different priorities that might affect the implementation of health promotion. In brief, the study offers recent findings in this largely unexplored area of research, it offers limited evidence on how hospital nurses perceive and practice health promotion within the hospital setting.

3.10.2 Jordanian Studies

As evidenced from the review of literature the contribution made by Jordanian researchers to the health promotion is limited. The reason the lack of research in this area is not obvious perhaps could be because research in health promotion in Jordan is still a new idea. However, there is an increasing awareness about its importance (Haddad and Umlauf, 1998, Nawafleh et al (2005). Another reason could be associated with the lack of financial resources directed for the support of health promotion research. Thus, the area of health promotion in Jordan needs further research attention. Despite their limitations (see below), few studies (n=2) have explored critical issues about health promotion in nursing. Their methodologies, implications as well as weaknesses are reviewed below.

Many international researchers (McBride, 1994, Furber, 2000, Cross, 2005), Haddad and Umlauf (1998) preferred the questionnaire survey to examine the attitudes of Jordanian nurses and midwives working in primary health care settings. Given this

aim, it was expected that the reviewed literature would include adequate knowledge about health promotion in its broad meaning such as empowerment and political agendas. This unfortunately was not the case. In Haddad and Umlauf 's study (1998) the theoretical framework was dominated by health education related issues such as individual to individual teaching. Thus, the topic of health promotion in this study was evaluated in a limited way. In spite of this drawback, there are some interesting findings of relevance to the current research, which are worth comment.

A translated version of nurses' views of health promotion questionnaire (Littlewood and Parker, 1992) was used. The instrument includes 18 attitudinal items that examine three areas of concern. This consists time constraints among nurses which could prevent them carrying out health promotion activities. The instrument measures also the responsibility and advocacy to health promotion within the nurses' role. Respondents were asked to indicate their agreement on a 4 points Likert scale (Strongly agree to strongly disagree). A panel of four experienced nurses in public health tested its content validity. Some revisions were made to the Arabic version of the instrument but no items were deleted or added. Internal consistency ($\alpha=0.78$) was computed from the responses of the target sample. Then, it was piloted with a sample of 23 Jordanian nurses. Although the above information is encouraging to use the scale, the review of its content raises some questions. For example one of the items was flawed as it contained more than questions, which would lead to unreliable response as explained below:

“ The physicians/nurses should take responsibility for health promotion” (P:522).

The above item is difficult to answer as the respondents could think that nurses should take the responsibility for health promotion but not the physicians or vice versa.

With regard to the instrument validity, it is also limited as the majority of items reflect health education related issues rather than health promotion. Given theses problems inherent in the instrument, the robustness of the study's conclusions is threatened.

The questionnaire was distributed to a sample of 120 nurses in primary health care settings and has achieved a 95% (n=1140) response rate. However, no information was given about the total numbers of nurses in health care centres and thus representativeness of the sample is debatable.

The majority of respondents were midwives 59% (n=71) and about one third 28% (n=33) were nurses. However, the number of participants was not equal in the two groups to facilitate a meaningful statistical analysis. The findings were that 50% (n=75) of respondents believed that the lack of time was the main barrier to carrying out health promotion activities. The author suggests that nursing management needs to address this issue.

Undoubtedly, this is an important factor but because of the highly structured questionnaire focusing only on time constraints, it was not possible to identify other factors. Evidence has shown that not only is the lack of time the main barrier to carry out health promotion activities but also the lack of knowledge, skills and resources (McBride, 1994, Davis, 1995, Furber, 2000, Irvine, 2007). Consequently, whether the former factors are applicable to Jordanian context is open to debate. Moreover, the responses to the item "I do not have time to carry out health promotion" cannot be thoroughly analysed, as no data were available from nurses about the meaning of health promotion. That is, it is not clear what is perceived as health promotion and that needs time to be investigated. Perhaps it would have been better if the questionnaire was accompanied by qualitative methods (e.g. focus group discussions) in order to offer more breadth data.

Interesting findings were that respondents expressed mixed feelings about whether nurses or physicians were the most appropriate providers of health promotion. A total number of 62 (43%) supported nurses whereas as 42% (n=60) believe that physicians were more appropriate professionals to promote health. Moreover, when the respondents were asked about whether or no they are willing to teach their clients about health related issues, again the respondents were equally divided. About 51% (n=73) agreed that teaching clients about their health is guilt inducing and victim

blaming whereas as 49% (n=71) did not agree with this. However, the above findings are mixed quantitative data and no conclusive evidence can be drawn to guide nurses' practice. Indeed, from other items it seems that Jordanian nurses were not sure about whether or not providing patients with health related information is suitable. About two third 62% (n=74) of participants believed that giving explanations to patients could worry them rather than reassuring them. On the other hand, 93% (n=111) suggested that helping patients to understand how their body works is vital for maintaining good health. It seems therefore that Jordanian nurses' understanding of health promotion is dominated by the medical model view of health which focuses specifically on the function of the body. This explanation, however, should be taken with care as the questionnaire itself was structured around medical health education activities.

Haddad and Umlauf (1998) concluded that both groups of nurses and midwives felt incompetence in providing health promotion. This conclusion however, lacks credibility as no observational data were obtained about nurses' ability to carry out health promotion activities. Further, it is not clear if this is related to the education, organisation culture or both.

Indeed, the highly structured questionnaire is not an effective method to evaluate skills (Polit et al, 2001). Thus, it could be suggested that using some observations of actual practices is advantageous. Haddad and Umlauf (1998) did not clearly recommend that but they assert that nurses' performance in health promotion needs to be addressed.

To summarise, the study offers vital but limited knowledge and insights into Jordanian nurses' attitudes towards health promotion. The study is a decade old now and needs to be replicated with different samples of nurses and methods. This is not only to verify its findings but also to update its evidence in the current growing debate in health promotion. Therefore, the need for more an updated research, including much more complex methods focusing on hospital nurses, is evident.

Whilst the following study has attempted to achieve this by using a multiple methods triangulation strategy, it has focused exclusively on primary health care nurses.

Nawafleh et al (2005) has explored the influence of HIV/AIDS on the practice of primary health care nurses. Whilst the study has focused on disease prevention and control, some emanating findings are of relevance to the current study's scope. Data were collected by participant observations, in-depth semi-structured interviews and documentary analysis (e.g. nurses' job descriptions). Six small health care centres were involved in Jordan. The study has focused on emergency nurses, as according to Nawafleh et al, (2005), they "provide direct nursing care" and they are in a good position to prevent HIV/ADS. These departments have included mainly aid nurses (a 1.5 year training nursing programme), practical nurses (a 2 year nursing programme) and registered nurses (a 4 year nursing programme). However, the number of nurses in each group was not given and thus it is not possible to examine the ratio of registered nurses to aid and practical nurses in this work.

Although the exact number of observations was not given, it was stated that, "an intensive period of participant observations were completed". Observations have focused on the care offered to patients at Accident and Emergency departments and activities involved in preventing possible AIDS infection. The exact number is not clear but it is reported that the internal key informants were interviewed. Whilst further details about the nature of selection procedure was not offered, the authors have personally selected them as " they have [certain] insights concerning the observed events. However, from the extracts provided it would appear that those who have been interviewed are either practical or aid nurses. That is, it seems that the in-depth interviews are likely to reflect the insights of those less qualified nurses.

Similarly, in depth semi-structured interviews were also undertaken with external informants. Whilst their numbers were not documented, they were recruited from Nursing Council, Nursing Directorates at Jordanian universities. Data were analysed thematically and validated by "internal informants". However, the inter-rater reliability test of the transcribed data was not established. Thus, the reliability of the

emerged themes is called into question. Importantly, the study has shown that the support structure such as effective nursing leadership and local mentorship were not features of most health care centres. The clinical knowledge and competence was limited and the poor understanding of risk management policy was evident. However, no examination was made to the nature of nurses' health promotion education. Although no empirical data were obtained from patients themselves, Nawafleh et al, (2005) suggest that their cultural beliefs affect the practice of nursing staff when it comes to control and prevention HIV/AIDS. Poor resources and the lack of education were the main factors affecting nursing practice. Interestingly these factors were reported elsewhere which are likely to prevent the development of nurses' health promotion role (McBride, 1994, Cross, 2005, Casey, 2007). Whilst the study is contextually limited, it seem that such factors are worldwide contributing to the quality of nursing practice. Nawafleh et al, (2005) concluded that the: "ability of nurses to raise awareness and therefore their ability to reduce the incidence of HIV/AIDs is currently is unrealistic" (p:205).

Nevertheless, the conclusion is mainly guided by evidence from less qualified nurses as outlined above. Such nurses have been criticised by an external key informant in this study, as "their standard of nursing practice is less than that provided by nurses in other settings" (P:204). Therefore, the study gives very sketchy evidence about the reality of Jordanian registered nurses' ability to promote health. The central problem in this research is the confusion about how data were collected and linked to the conclusions. However, this highlights the need for a more robust research that might offer clear evidenced based implications for practice, education and research.

3.10.3 Health Promotion from the Perspective of Patients

In chapter 2 it was found that some studies have attempted to understand how health is perceived among patients. By contrast, very limited studies reported on their understating of health promotion and related experiences. To date, however, no study was found to systematically examine the two related concepts among hospital patients. Thus, it is not clear if nurses' role in health promotion match patients' own

understanding of both health and health promotion. This is an important point as the delivery of competent health promotion activities needs to be derived by evidence on how patients conceptualise such terms (Yaoho and Ezeobele, 2002). Relevant studies, together with critique, are explored below.

In her recent work, McBride (2004) studied patients' receptivity to health promotion in an acute hospital setting. A cross-sectional survey design using a structured questionnaire was used to examine patients' attitudes towards health promotion in England. All patients from emergency and planned admission, aged between 16 and 64 years and who been in acute hospital for at least 48 hours, were selected by the ward staff. Patients were asked to agree or disagree with statements regarding health promotion and lifestyle issues using a 4 point Likert scale. The questionnaire has mainly investigated patients' attitudes about smoking policy in hospitals. Of 320 patients approached all agreed to participate in the study, giving the study a 100% response rate.

The findings were that a total of 95% (n=304) support health promotion development within the hospital. Most of them 80% (n=256) expressed a wish to modify some aspects of their lifestyle behaviour. About 81% (n=235) take notice of what nurses' say to them about lifestyle and 73% (n=100) said it was useful. The majority of respondents, 77% (n=237) would like smoking to be banned for staff and 79% (n=250) said it should be banned for patients. The author concluded that patients are generally receptive to health promotion in hospitals but they have concerns about translating their positive attitudes into practice. Whilst the study's generalisation is perhaps satisfactory due to the excellent response rate (n=320,RR=100%), it is not however free from limitations. In fact, the identification of patients to participate in the study, by the ward staff, raises concerns about possible selection bias which might threaten the findings.

Also it should be noted that the first 48 hours of patients' admission is a critical time and developing a trusting relationship with nurses might be difficult. Thus, the identification of hospital nurses' experiences of health promotion might be

constrained by the study inclusion criteria. It could have been better if the study inclusion criterion included those patients who had been in hospital for at least a week to allow adequate contact with nurses and thus offer more possible experiences of health promotion. Whilst the structured questionnaire is an effective method to obtain data about a large sample size, its findings are superficial. The patients' receptivity to health promotion in McBride's (2004) study, for example, has been described only statistically but their subjective experiences of health promotion activities remain unexamined. The complexity of possible responses was constrained by preformulated items included in the questionnaire. Whilst a full copy of the questionnaire to assess its quality was not provided, the statements reported such as "patients' lifestyle" and "take notes of what nurses say" indicate that the questionnaire had focused on health education related issues rather than health promotion. Moreover, items reported were all negative about smoking related issues. Thus, it is not surprising that many participants agreed with them (Socially desirable answers). It is not clear if negative items about smoking were balanced with positive items and thus the above critique cannot be ruled out. It might be better, for example, to include items such as:

"Smoking is good during the hospitalisation time as it reduces the anxiety"

Such an item might offer some valuable data on unhealthy coping mechanisms used by patients and related beliefs during hospitalisation. However, the study highlighted the fact that hospital patients are interested in changing their lifestyle behaviour and their attitudes were positive for developing health promotion activities within a hospital setting. But caution must be exercised against the credibility of these findings due to the limitations identified above.

Recently, Carroll and colleagues (2007) explored how health promotion is conceptualised among Somali refugee women in the US. The researchers used in-depth interviews with 34 women from the Somali refugees' community. Inclusion criteria included those women >18 years and born in Somalia. The sample was selected using the snowball technique. This was carried out by key informants as

well as primary care providers in the community. However, whilst this might help to identify those who meet the study's eligibility criteria, selection bias in the above procedure cannot be ruled out. On this basis, the sample might represent those who hold certain attitudes and understanding of health promotion. To add to the problem, although the researchers claim that the focus of the study was on health promotion, the development of methods is a reflection upon medically informed health education (see below).

The interviews revolved around preventative beliefs and practices as opposed to empowerment and socio-economic issues. The latter is an important dimension to the study target, especially when encountering those who might be less privileged in the society (e.g. refugees). The enclosed appendix about the semi-structured interviews suggests that the study was only about one aspect of health promotion. That is, preventative measures to health as opposed to promoting positive health. This is reflected in the following questions

“What health problems do Somali women worry about?”

“Have you ever heard of words “preventive health care”, health prevention or screening test?”

Given the status of women refugees in the US, it might have been better to carefully develop the above questions. For example, it might have been important to ask participants “what problems do you, as a refugee here, suffer from?”. This general open-ended question might have generated issues related to wider issues in health promotion such as social injustice, economic problems and health inequalities.

The findings were analysed by the researchers using the grounded theory approach. However, in light of the developed questions (see above), it is not clear what sort of health promotion framework was used for examining the data. Whilst no detailed account was given, a focus group discussion was undertaken with participants to check the validity of response. Coupled with the study on a preventative health focus,

it gives little indication on how women view health promotion from its wider perspective. Yet participants viewed health promotion as good hygiene, adequate water and food, spirituality and “functioning well at home”.

Whilst numbers were not given, the researchers found that “most participants reported their health to be very good with relatively few worried about health” 375. (P:376). Whilst the above findings offer valuable insights into refugees’ needs of health promotion in order to be fulfilled, they should be taken with care. Although they might reflect the reality, the positive findings about their health might be related to the problems with the research itself. As presented earlier, community care providers were involved in the sampling process. Thus, participants might have felt that offering negative images about their health and health care service could have a bad impact on the quality of care they receive in the future. This postulation is reinforced by the lack of anonymity in the research as well as participants’ social status as refugees. The researchers concluded that “efforts should be made to increase knowledge for all Somali women.... about the rationale for preventive services such as cancer screening” (Carroll et al, 2007, P: 378). The conclusion simplifies the complex world of individual’s behavioural change process. That is, it is based on the inaccurate assumption that offering health information will result in more health promoting behaviour (see socio-cognitive theories of health promotion in this chapter).

In brief, whilst it identified important needs to be met for the Somali women, the study is threatened by a number of limitations. This includes the study health education focus as opposed to health promotion and the possibility of selection bias.

Further, the study included only women and thus the applicability of its findings to men is debatable. This highlights the need for a more methodical empirical work including both genders. Finally, the sample included community patients and, given the difference in the environment, it is not possible to generalise these findings to the hospital setting.

3.10.4 Conclusion Of Previous Studies

Based on this review, it seems that few studies have examined nurses' role in health promotion in hospitals. Although recent health promotion ideology was developed over the last decade, there has been limited empirical evidence available to exclusively assess the extent to which its principles are implemented in practice by hospital nurses. Whilst their contributions to the knowledge are valued and they guide the development of this study, previous studies suffer from significant limitations. They are small scale research, do not provide statistically significant findings are largely guided by self reported data and failed to scrutinize the link between nurses' perception and actual practice due to the lack of observation (Cross, 2005, Casey, 2007, Irvine, 2007, Whitehead et al, 2008). Some are a decade or more old now (McBride, 1994, Davis, 1995, Maidwell, 1996, Haddad and Umlauf 1998, Furber, 2000) and their conclusions are threatened by the selection bias of the sample of participants (Davis, 1995, Maidwell, 1996). Therefore, they need to be replicated with different samples and methods to verify their findings and reflect the growing recent debate in health promotion.

Although some studies found that a hospital nurse's role in health promotion is limiting and focussing on behavioural change approach (Furber, 2000, Cross, 2005, Irvine, 2007), others reveal that their role has developed towards health promotion values (McBride, 1994, Whitehead et al, 2008). In light of this, the literature offers conflicting rather than conclusive evidence and thus draws a firm conclusion about hospital nurses' role in health promotion being a complex task. The methods used reflect the study aims and focuses on the outcomes of the research as opposed to the process itself. That is, it is difficult to see how the evidence was generated, revolved and debated.

Considerable literature exists debating nurses' role in health promotion (Whitehead, 1999, 2001, 2003 Kim et al, 2003) but what is striking is that when this role is examined by research, the methodology is developed around behavioural change and individualistic interventions as outlined in this chapter (McBride, 1994, 2004,

Maidwell, 1996, Cross, 2005, Nawafleh et al , 2005, Irvine, 2007). Conversely, the lack of systematic research exposing the link between organizational culture and its impact on the development of hospital nurses' role in health promotion remain. These issues were superficially examined in previous studies (McBride, 1994, Crross, 2005, Irvine, 2007, Whitehead et al, 2008) due to the prescriptive methodology used. Likewise, none of the studies reported here has examined how both hospital nurses and patients understand the concept of health promotion. Yet it is argued that health promotion is influenced by staff's attitudes, their knowledge and the norms of those who will be targeted (Groene and Jorgenson, 2005). To add to the problem, none of the studies has matched empirically hospital nurses' understanding of health and health promotion and thus it is not clear if hospital nurses are aware of what it is that is to be promoted in the first place. Furthermore, many of the reviewed studies in this chapter were carried out in countries other than Jordan. Although they offer valuable data against which the emerging findings from this work are discussed, their applicability to the Jordanian context is questioned. This is due to the nature of health care system and nurses' education and training.

To conclude, health promotion is vast and the nursing research contribution in this area is limited. Yet there is a huge empirical task ahead if nurses need to move away from the tension that exists between health promotion theory and current practice towards a coherent reform of health promotion (Whitehead, 2005, Casey, 2007). Therefore, there is a need for systematic and current research that addresses hospital nurses' roles in health promotion from different perspectives (e.g nurses themselves and patients). So doing might guide the development of hospital nurses' role in health promotion. Once the barriers that hinder such development have been identified, future strategies can be devised to overcome them. By including other populations of nurses, patients and hospital stakeholders (e.g hospital managers and nursing managers) from Jordan, it is hoped that valuable Middle Eastern information could be provided to guide the future development of hospitals nurses' role in health promotion. How this might be achieved is the focus of the chapter on methodology methods.

Chapter Four: Methodology and Methods

4.1 Introduction

The aim of this study was to understand the role of Jordanian hospital nurses in promoting patients' health. To this end, some key issues need to be explored. More specifically, the study attempts to address the following questions:-.

1. What is nurses' knowledge and understanding of the concept of health and health promotion?
- 2- What is patients' knowledge and understanding of the concept of health and health promotion.
- 3- What are nurses' and patients' attitudes and beliefs towards health promotion in hospitals.
- 4- What are nurses' and patients' perceptions of their experiences of health promoting activities?
- 5- What are the factors identified by the key hospital stakeholders (Training and development manager, surgical and medical wards supervisors and a nursing educator) which might affect the practice and the development of nurses' roles in health promotion.

In order to adopt an effective research approach, it is argued (Polit et al, 2001, Fisher and Ziviani, 2004, Williamson, 2005) that the key areas of the investigation need to be identified. From the questions outlined above, it seems that this work consists of a range of areas for investigation. This includes not only nurses' knowledge of health promotion and contributing factors involved but also how it is practised in reality.

Although the contribution of earlier studies to the body of health promotion literature is acknowledged (Furber, 2000, Cross, 2005, Casey, 2007, Whitehead et Al, 2008), their conclusions are often based on one method. As a result they do not offer comprehensive evidence about the reality of complex issues like health promotion (Tones and Green, 2004). The current research attempts to take these issues into account. The study utilised a constructivist case study design using a multiple method research strategy. The research approach (methodology) which underlines the overall research process and a facilitated description the reality of hospital

nurses' role in health promotion is examined in the next section. Then, what methods are needed to expose and explore such reality is highlighted and followed by a discussion about the study design.

4.2 The Study's Methodological Approach

Since the 1950s, quantitative research (positivist) had been the dominant approach in health research especially nursing (Burns and Grove, 2001). It highlights the view, although disputed from a qualitative point of view, that human behaviour is objective, observable and quantifiable. Whilst such an approach is essential to study the link between variables related to health promotion (e.g. length of experience and attitudes of nurses) (Gillis and Jackson, 2002), it fails to gain in-depth understanding of a certain experience as it happens (McPherson and Leydon, 2002). Likewise, it is argued that quantitative research could successfully point out the link between people's understanding of health and their cultural beliefs but it fails to explain why such a link exists in the first place (Foss and Ellefsen, 2002, Aled and Bugge, 2006). That is, there are several issues overlapping in health promotion and thus a quantitative approach alone might make little contribution to the investigation (Tones and Green, 2004).

It is not surprising therefore that qualitative research has been given considerable attention in recent years with particular reference to health promotion. This is due to the fact that examining health promotion within the context of certain settings such as a hospital is not a straightforward process. It is argued that an understanding of health promotion related issues and professionals' practices of its principles are incomplete unless the subjective reality of health and ill health that affect individuals is captured within a certain setting (Tones and Green, 2004). This sits well with the arguments that health means different things to different people in a different health care system (Seedhouse, 2004). There is therefore a need for exploring different realities of hospital nurses' role in health promotion in a certain culture which could lead to a better developed and informed conceptual model for health promotion. To this end, the study is based on a constructivist research paradigm highlighted by

Lincoln and Guba (2000). The epistemology of this approach is based on the argument stating that :

“There are multiple realities [integrated] in the form of multiple[constructs] (Guba and Lincoln, 1994,p,110).

Indeed, the constructivist approach focuses on individuals’ meanings of events that are contextualized. That is

“ [understanding the reality] involves coming to an understanding of the view of the world held by those people involved in the situation rather than adopting a “stranger” or outsider perspective (Rodwell, 1998, p, 27).

On the basis, the current researcher needs to recognize that the problem under investigation has multiple realities that need to be exposed from the inner perspective of participants.

Likewise, Scholars (Denzin and Lincoln, 2000), argue that the constructivist approach does not only enable participants to describe their stories about the reality, but also identify the potential actions to overcome certain barriers (Robottom and Hart, 1993, Baxter and Jack, 2008). That is, the constructs of the reality (nurses’ role in health promotion) will be examined in light of the inhibiting factors to its development.

The above argument is consistent with the overall aim of the study. That is, a better understanding of nurses’ role in health promotion is served through an exploration of related multiple constructs in a specific health care system. This is particularly relevant to the current study, where the constructs under investigation are nurses’ and patients’ understanding of social and cultural realities of health promotion work (Quinn Patton, 2002).

More specifically, the importance of the constructivist approach is highlighted by the qualitative research community. The scholars (Foss and Ellesfen, 2002, Fontana and Frey 2003) argue that such a research approach is desirable when there is very

little known about the problem under investigation; if the problem cannot be separated from the participants' context and if the purpose is to explore how several issues interact in a natural setting. Rodwell (1998) agrees with the above criteria but argues further that the constructivist approach is recommended when the inquiry needs significant interactions between the researcher and research participants so a complex understanding of the problem can be achieved.

The current research problem and its questions have met these criteria. As Chapter three shows, nursing health promotion within the hospital setting has not yet been adequately addressed in the international research and in Jordan no study was found in this area. Furthermore, the constructivist study of nursing health promotion activities as they occur in a natural hospital setting contributes to our knowledge of the application of this methodology.

Thus, the factors affecting health promotion activities cannot be divorced from the hospital context. Furthermore, there are diverse and overlapping realities that need to be examined. These include, "attitudes towards health promotion", "practice of health promotion" and "experiences of health promotion". Finally, given the complexity and diversity of health promotion (e.g. health policy and organisational structure), the study employed a number of methods (e.g. observations, interviews) in order to allow a significant interaction to take place between the current researcher and participants involved. Thus as pointed out by Rodwell (1998) a better and more comprehensive understanding of nurses' role in health promotion can be achieved.

The constructivist approach in this study involves the use of induction (the discovery of constructs or patterns) and deduction (testing the overall constructs) in relation to the literature (Guba and Lincoln, 1994). In line with this argument, it is recommended (WHO, 1998) that the constructs of health and health promotion need to be studied quantitatively and qualitatively to cover a wide range of overlapping issues such as gender and cultures and to inform the development of a conceptual model in health promotion (Tones and Tilford, 2001). Such a proposed model needs to be underpinned by relevant theoretical and empirical constructs

(Nutbeam, 1999). How to generate as many constructs as possible of importance to nurses' role in health promotion is the focus of the next section.

4.3 Mixed Methods and Triangulation

The research involves both quantitative and qualitative components in order to explore and test constructs of nurses' role in health promotion. However, within the constructivist approach and when the problem has not been examined before, it is recommended that the qualitative component is to be the larger so more realities are to be exposed and constructed (Guba and Lincoln, 1994). Such realities need to be uncovered from the internal perspective of individuals rather than by a pre-established highly structured method as is the case with previous work (Dickinson and Bhatt 1994, McBride, 1995).

However, eliciting some quantitative data about a multifaceted problem, allows a more robust evidence based implication to be drawn (Polit et al, 2001). In this study it was felt that using a quantitative method (questionnaire) would overcome the weakness of the qualitative methods (e.g. focus group discussions) such as the complexity of establishing its validity and reliability. Statistical data from the questionnaire in this work could enable the generalisation of certain themes /constructs found in qualitative materials. On the other hand, qualitative materials would add breadth and depth to the constructions of the reality of Jordanian hospital nurses' role in health promotion (Gillis and Jackson, 2002). Driven by the above arguments, the study used a model of exploring qualitatively the social construct of the reality of hospital nurses' role in health promotion and then testing them quantitatively by the questionnaire and deductively against the existing literature. This allows a level of methods triangulation to take place as illuminated below.

4.3.1 Triangulation

Triangulation research within the health context has attracted many writers in recent years (McPherson and Leydon, 2002, Fenech and Kiger, 2005). However, in this

review the focus will be on method triangulation and how it could enhance the overall rigour of this work. Potential problems associated with its utilisation also will be illuminated. Arguably, it has been pointed out that the multiple methods for the collection and interpretation of data about a phenomenon could result in eliciting an accurate representation of reality (Denzin, 1994, Foss and Ellefsen, 2002). Taking this argument further, it was pointed out that if there is a truth it is to be found in unexamined phenomenon and diverse methods need to be utilised to find it (Denzin and Lincoln, 2000). On this basis, it can be argued that the combination of multiple methods in a single study adds depth and breadth to the investigation. That is triangulation offers in depth understanding of a phenomenon in question that is a subject for speculation (Denzin and Lincoln, 2001).

With the above analysis in mind, it is not inappropriate to argue that both nursing and health promotion are a complex field with many intertwining factors to consider. For example, as discussed in Chapter 3, health promotion operates at diverse levels ranging from individualised to both social and political spheres and thus many factors and challenges involved. Thus no single method can capture the majority of its convolution. It is not surprising therefore that the WHO, (1998) urge researchers to adopt to utilise a full range of quantitative and qualitative methods.

Although the recent review of the literature has shown that method triangulation has not yet been given significant attention in health promotion area, it is, however, widely used in other areas in nursing research and it is deemed as a robust strategy. For example, Williamson (2005) has recently used method triangulation to examine satisfaction and the level of burn out among nursing students during their placement. A series of four focus group discussions were used. Then, a questionnaire informed by their data, was also used. The study results are not of relevance here, but Williamson (2005) offers some reflections into the usefulness of triangulation. The results from both methods have contributed to more informed recommendations being made. Williamson (2005) concluded that:

“Triangulation forced me to look at the data in the widest possible manner and subject analyses to critical scrutiny.... instead of simply accepting findings from one methodological paradigm [which could result in eliciting less credible conclusions]” (p:17).

In the light of the above discussion, the first key advantage of employing methods triangulation in this study is the “completeness”. It means that the phenomenon is approached from a number of vantage points to gain a holistic view about its nature and related issues. Consequently, a more coherent data can be created and the overall credibility of result is maximized. However, in opposition to this, one key limitation of previous research in health promotion is the narrow evaluation of this area of research. This is exemplified by relying extensively on data emanating from a single method coupled with an exclusive focus on either patients or nurses (See Chapter 3: McBride, 2004, Cross, 2005, Irvine, 2007). It is recognised here that health related issues in a specific culture can never be completely understood regardless of the number of methods employed (Kim-Godwin et al, 2001). However, using triangulation of methods in this study contributes an additional piece of the puzzle that could allow further understanding of such a phenomenon to be gained (Adami, 2005)

Denzin (1994) suggests that method triangulation can occur in two forms. Firstly, within method triangulation which involves different strategies within one method (e.g. survey method using different scales to measure the same empirical unit). Secondly, between method triangulation, which involves different methods, examining a single phenomenon. Both of these forms were evaluated in terms of suitability and applicability to this work.

The first form is deemed as unsuitable as the same paradigmatic method weakness is replicated many times in the same study (Silverman et al, 2001). Thus method triangulation has been used as it has the potential to overcome the inadequacies of each method (Williamson, 2005). Indeed, it is hypothesised that this form of triangulation can better enable researchers to carry out “self checking” function, increasing the researcher’s confidence in the results themselves and better enabling

their communication to a wider audience (Foss and Ellefsen, 2002). Therefore, each method in this research was used to check the validity of data generated from another method and thus establishing the rigour of the work can be facilitated. However, for the purpose of confirmation in triangulation research, weaknesses as well as strengths of data collection methods need to be identified (Bolwing, 2005). Then they will be counterbalanced to minimize the threat of low validity (Shih, 1998, Aled, and Bugge, 2006). For example, the questionnaire in this study could suffer from the criticism suggesting that its findings are often superficial. On the other hand, focus group discussion results are often lacking generalizability (Morgan, 1997). The weakness of the first method is the strength of the second method and vice versa. Thus, the gaps in each method are bridged.

However, a word of caution must be sounded here. Confirmation should not be taken as the central advantage of this form of triangulation in this thesis. Arguably it is contended that, when using varying methods of triangulation the researcher should not expect that different methods of data would confirm one another. Rather the expectation is that each source will contribute to an additional “piece of puzzle” (Denzin and Lincoln, 2000). That is, although they are related in this study, each method has its own unique contribution aiming to offer adequate empirical knowledge about hospital nurses’ role in promoting patients’ health in Jordan. The challenging question is that what research methods needs to be used first? (Razum and Gerhardus, 1999). The question is of interest to the current work and would be worth answering. To this end, two models of combining both quantitative and qualitative methods were examined (Denzin, 1994).

Firstly, there is a parallel model, which begins by using quantitative methods to verify the link between variables, which have been identified previously in the literature. Then they are examined in-depth qualitatively. Although qualitative materials can enhance statistical evidence, this model has been excluded in this research. Internationally, the available quantitative methods are poorly developed as shown in chapter 3 and the link between variables is vague. More specifically, no study has been found in Jordan that exclusively examines health promotion in

hospitals and thus no quantitative database was available for the current researcher. Taking these problems together it would not be possible to standardize a quantitative instrument and to inform its cultural content.

The second model which is referred to as “subsequent” or “chronological” was deemed to be more suitable. It informs the overall development of the study’s methodology plan when the problem has not been examined before (Gillis and Jackson, 2002). In this model, qualitative methods are used for the first stage of research. This allows empirical evidence to be built through discovering key issues and narrative data needed for the development of subsequent stages of the research. Although more time and research skills are needed for this model, it is fairly straightforward. That is, the question, sample, method and analysis plan for each method were initially described separately and then all the emanating data integrated together. Considering the chronological model of triangulation, the following methods have been used:

- 1- Focus group discussions with nurses.
- 2- Non participant observation.
- 3- Questionnaire
- 4- Focus group discussions with patients.
- 5- Interviews with hospital stakeholders and the nursing educator.
- 6- Documentary review (e.g. nurses’ job description and health policies)

In order to address the research aim, focus group discussions and observations were used first with hospital nurses. This is in order to inform the development of the questionnaire and focus group discussion with patients and individual to individual interviews with hospital stakeholders. Moreover, the key gap in observation method is that participants could change their behaviour, which is referred to as the “Hawthorne effect” and thus data validity are threatened. Using data from other methods would allow the researcher to verify the credibility of such data (Polit et al, 2001). This is to be discussed in a detailed way in the observation section.

In this research, the collection of information and its analysis progressed concurrently. This allowed the current author to sift through existing information and gain insights, to identify new questions emerging and to call for additional evidence

to confirm or contradict the insights (Williamson, 2005). This is opposed to those deductive and highly structured studies (Maidwell, 1996 McBride, 2004, Cross, 2005) in which their methods are developed in advance. Using an inductive process, the research integrates the empirical evidence to develop a framework that could explain the problem under investigation and thus more credible conclusions could be drawn. Doing so increases the cultural suitability of the research instrument (Gillis and Jackson, 2002), and addresses the content validity of the method as it is not only based on theoretical literature but also on evidence produced from each previous method (Magnusson et al , 2005). That is, the reliability of the method is maximised as the researcher would be familiar with participants' own phraseology (Jones and Bugge, 2006).

4.3.2. Problems Associated with Triangulation

1- Paradigmatic Problems

Whilst method triangulation has vital advantages to the current research (see above), it poses some problems of concern. The theoretical assumptions of sampling for both quantitative and qualitative approaches are different. It is argued (Foss and Ellefsen, 2002, Williamson, 2005) that whilst the former rely highly on the sample size and normally distributed data, the second tends to use a small sample size that give in-depth illustration. These issues need to be considered otherwise the research would generate errors and conflicting paradigmatic issues (Anthony, 1999).

However, whilst the emanating data from each method in this study are interconnected, the above sampling issues were taken into account. For example, endeavours were made to select a large sample size for the questionnaire in order to gain a satisfactory generalisation matching the quantitative research needs. On the other hand, focus discussion with nurses and patients used a smaller sample size (n=6-12) as the aim was an in-depth illumination rather than a statistical generalisation (Morgan, 1997). It seems therefore that sampling issues in this work were considered in light of principles underlying the research paradigm.

Likewise, whilst quantitative approach (positivism) views the reality objectively and in a measurable way, qualitative approach perceives it as changeable and subjective issues (Gillis and Jackson, 2002). Utilising these approaches together could lead to epistemological conflicts. It is no wonder therefore that Phillips (1988) warned earlier against those inquiries blending methods, arguing that quantitative and qualitative approaches are epistemologically inconsistent. Yet this argument has been weakened in recent years and the debate has moved forward. In fact, scholars (Denzin, 1994, Tobin and Begley, 2004, Aled and Bugge, 2006) dispute the above argument and go further to suggest that viewing triangulation as only blending methods is a narrow one. They argue that researchers need to expand the use of different methods to establish the rigour base for their findings. In accordance with this argument, triangulation is not only blending different methods, rather it is a validating tool for constructing the reality of hospital nurses' role in health promotion. That is, as the integrity of each approach was not breached and both are equally valued, it could be argued that the epistemological disparities would not threaten the overall design of this work. Taking all the arguments together, it seems that there is no reason why different approaches cannot be used together to generate more robust evidence and thus more effective implications for practice.

2 - Data Analysis Problems

Triangulated research could introduce a dilemma when it comes to data analysis. Conflicting data is often reported as a serious problem of such research strategy and could be seen as the reason for not using triangulation (Foss and Ellefsen, 2002). This possible pitfall was considered in advance before data collection had taken place. Although the literature gives little guidance on how to deal with conflicting data, Razum and Gerhardus, (1999) recommend that the researcher needs to accept the superiority of one established method over a new one. They cite an example asserting that nicotine level in urine offers more credible data about smoking behaviour than a questionnaire examining the same problem.

However, the dilemma here stems from the fact that there is no physiological measures used in this research and such a solution has no place in this study. Overall,

it is argued that conflicting data could enrich results as they stimulate researchers to creatively analyse data (Shih, 1998). Likewise, McPherson and Leydon, (2002) postulate that the formal verification is not the formal aim of triangulation, which attempts to study holistically a multifaceted phenomenon. In light of this, if conflicting data have emerged in this research it will not be considered as a flaw. Instead it will be seen as a stimulating tool of debate that would enable a certain conclusion to be examined within the context of diverse evidence.

Generally speaking, some data sets might be more suitable to address a particular research question than others, for example, if the questionnaire was delivered to a larger number of nurses than those in focus group discussions. Reasonably, it would address more effectively the overall nurses' views towards health promotion (deductive picture) . On the other hand, observation would offer more "actual data" than the questionnaire when it comes to understanding what nurses do in the name of health promotion. That is, whilst all data sets in this study attempt to offer an accurate account about nurses' role in promoting patients' health, findings of specific data could outweigh others during triangulation. This commented on later in both findings and discussion chapters. Meanwhile it is essential to point out that the decision about whether to weigh one data set more than another was determined on a case by case basis. Keeping in mind the work of Farmer et al (2006) about analysing triangulated research data, such a decision in this study was driven by the characteristics, objectives of specific research method as well as the research main aim.

To sum up, the nature of the complexity of health promotion related issues together with the diverse aims of this research has led to the development of a more coherent methodological strategy. Multiple methods triangulation adds depth and breadth to the understanding of the current investigation, which in turn might maximize its rigour (Williamson, 2005). However, whilst employing this strategy has key benefits such as completeness and confirmation, this is not to over-advocate triangulation research and claim that there is no place for single studies method in health promotion areas.

What is argued here is that triangulation has significant impact on interpretation of the current work findings and indeed it offers an opportunity to transcend the weakness inherent in a single method. That is, for example, the quantitative findings are viewed as adding “spice” to the “real” results and further explain the qualitative findings (Foss and Ellefsen, 2002).

By contrast, qualitative evidence can be used to produce hypotheses that are then tested quantitatively in the future. Subsequently, it is argued that the high quality methodology in health sciences including cultural issues, needs to involve asking questions, listening and watching, (Denzin and Lincoln, 2000, Shih, 1998). Accordingly, the former elements have been incorporated together in this study. However, no matter how many and what the research methods are, a specific research design is needed to allow them to be integrated together if the research aims are fruitfully to be addressed (Polit et al, 2001).

4.4 Case Study Design

In line with the study methodology (see above) and in order to address the study questions in a natural setting, a constructivist case study design was used. Such a design is effective when the issues of the problem under investigation are overlapping and have not previously been examined (e.g. hospital nurses, gender and the health organisation itself) (Fisher and Ziviani, 2004). The constructivist case study design explores a phenomenon within its context using multiple data sources to identify the constructs of the realities. This fits with the methods triangulation strategy explained earlier.

The medical systems and cultural systems differ from one society to another and sometimes within the same sectors of the same society (Kim-Godwin et al, 2001). This implies that in-depth constructivist case study design is desirable. In light of this, the current research has exclusively focused on one hospital with the boundaries of a specific culture

Unlike descriptive case study design, in this research exploration does not only describe the reality of hospital nurses' role in prompting patients' health but also it attempts to explore those contributing factors to this role. Thus a fuller picture can be captured about hospital nurses' role in health promotion.

Other scholars (Denzin, 1994, Gillis and Jackson, 2002, Bergen and While, 2000, Yin, 2003) propose that such a design is effective when a contemporary phenomenon is to be studied in its natural context and the focus is in understanding the dynamic interaction between different individuals in that setting. More specifically, the case study design is recommended when : (1) "How" and "Why" questions are being asked to examine a multifaceted problem in a specific culture (2) When the link between the participants and the "real-life context" is not evident and (3) when the researcher has little control over events. (Bergen and While, 2000, Yin, 1994, 2003,).

When the nature of the current research and its aims are examined against the above criteria, it is apparent that such as a design is effective for this study. For example, the study was undertaken in a natural setting located in a certain culture. Likewise, it is not possible to control the events as they happen (e.g. patients' admission and discharge procedures). Indeed, the relationship between nurses, patients and the hospital as an organisation is not clear. Consequently such a design was deemed as the most appropriate design to utilize in this research.

However, this decision has not only been rationalised by the above discussion but also upon an evaluation of the applicability of other research approaches. Although ethnographic approach has a potential to study a complex health problem within a natural and a cultural setting (Polit et al, 2001), it has been ruled out. Although Willis, (2007) argues that case studies are much more similar to ethnography than dissimilar, the success of the latter depends on specific criteria which should be met. Ethnographic research can require the researcher to spend a long time (e.g. months and even years) in the field using participant observation (Gillis and Jackson, 2002). This is in order to create the "perfect spy" which enables the researcher to obtain all the knowledge necessary on a daily basis (Denzin, 1994). However, the current study

is time limited and such a form of observation has not been used for cultural and methodological reasons given later in this chapter.

Action research is an effective research design to evaluate health promotion program and create a tested action plan (Whitehead et al, 2003a). However, as action research is cyclical in nature (fact finding, action and reflection which generate a new inquiry), it may take longer to complete and thus more resources are needed to achieve its goals (Whitehead et al 2003a). Action research needs to show that a certain health problem has been resolved as a result of a specific intervention. In this study, whilst a conceptual model that might contribute to the development of hospital nurses' role in health promotion is proposed, the aim of the study was to understand their role in health promotion rather than to examine a certain program or actions to bring about measurable organisational change (Gillis and Jackson, 2002).

Further, whilst the phenomenological approach could be suitable to address nurses' and patients' experiences of health promotion (Burns and Grove, 2001), it does not suit other research questions. Some of them simply do not have an exclusive focus on participant's experience that fits phenomenological criteria (Racher and Robinson, 2002). For example, the study attempts to highlight the nurses' attitudes towards health promotion in relation to the overall hospital functional role.

Finally, using both deductive and inductive methods in this research within the framework of a phenomenology approach could raise paradigmatic problems. This is because the principles of such an approach are purely inductive in which data are collected at a micro level (Denzin and Lincoln, 2000).

By contrast a constructivist case study design in this study has significant flexibility. Diverse methods can be utilised regardless of their methodological ideologies as long as they explore and test different realities of hospital nurses' role in health promotion (Guba and Lincoln, 1994, Yin, 2003). That is, in this study, the emerging constructs of hospital nurses' role in health promotion are examined against the existing literature as well as tested quantitatively within the case study borders (surgical and medical wards).

In order to examine in-depth certain events at a “micro level”, a unit analysis has been used. Each setting (e.g. surgical and medical wards) within the hospital context has been considered as case study. That is each case study has its own uniqueness and a contribution to make (Yin, 1994). Such a tactic enables cross case analysis as well as comparisons to be made among diverse settings (Bergen and While, 2000, Yin, 2003). However, it should be noted that previous studies have been criticized on the ground of the exclusive focus on one setting (Maidwell, 1996, Cross, 2005, Irvine, 2007). It can be argued therefore that this study might offer a more coherent picture about the nature of nurses’ role in promoting health and contributing factors.

4.4.1 Problems with Case Study Design

As the case with other research approaches (see above), case study design has its own problems to be considered. These are detailed below:

1- The Role of the Researcher

In case study design, the data collocation and analysis depend heavily on the researcher’s background and interpretation of events (Yin, 1994). This could limit the validity of the research and thus its overall rigour is confined. Whilst this cannot be completely eradicated as bias can enter any research (Gillis and Jackson, 2002), it can be reduced by taking some measures. The data in this study were exposed to some participants (respondents validation) so the extent to which their views are reflected in transcribed data can be checked. This is explored in more details in the section of Trustworthiness of Data. Indeed, Yin (2003) argued that the case study design is strengthened by triangulation research as it allows the phenomenon to be examined holistically and thus the results are valid and reliability is enhanced.

The role of the current researcher was identified and certain frameworks were used to minimise his influence on the data collection process. Before entering the field the researcher’s knowledge and beliefs about health promotion were “bracketed” (Frankfort-Nachimas and Nachimas, 1996). He reflected on what he collected, heard and observed. A justification was offered and recorded before considering data as legitimate. Data were generated rather than discovered and fitted the associations that

conceptions are not pre-existing phenomena waiting to be discovered, but rather they include relations (Khishfe and Abd-El-khalick, 2002). The framework developed by Sirvastava (2005) was used to offer a balance between the current authors' reflection, imagination, interactions and what is really collected. The following questions were used throughout data collection and analysis:

- 1- What are the data telling me?
- 2- What do I want to know?
- 3- What is the relationship between one and two?

The first question attends to links between claims and evidence. The second question refocuses the current author's attention on the study aims. Question three assesses the dynamic interplay between the current author's aspects of interpretations and what data really tell him about a certain issue. Thus, the current researcher kept a balanced account between what is interpreted and what is the reality of a certain problem.

2- The Lack of Generalisation

The case study design has been challenged owing to the lack of generalisation (Burns and Grove, (2001). However, this accusation within the context of the current research should be approached vigilantly. The aim of case study is to understand and emphasise the complex and uniqueness of the case rather than to generalize findings (Creswell, 1998). Likewise, Bergen and While (2000) argue that generalisation is informed by sampling theory, which is based on representativeness. According to them, this is not applicable to case study research as every one and its natural context is unique (Bergen and While, 2000).

The aim of case study design in this research is illumination rather than representation. On this basis, no claims are made here to suggest that findings emanating from this study are able to be statistically generalised to other Jordanian hospitals. However, Yin (2003) in his most recent debate about the above subject matter, argues that if statistical generalization is not possible from the case study design, theoretical or analytical generalization fits such a design. It offers explanation

of a particular phenomenon derived from empirical research, which could be applicable to similar settings. That is, theoretical explanations of a certain issue of health promotion might help to understand underlying factors affecting nurses' role in health promotion in other hospitals.

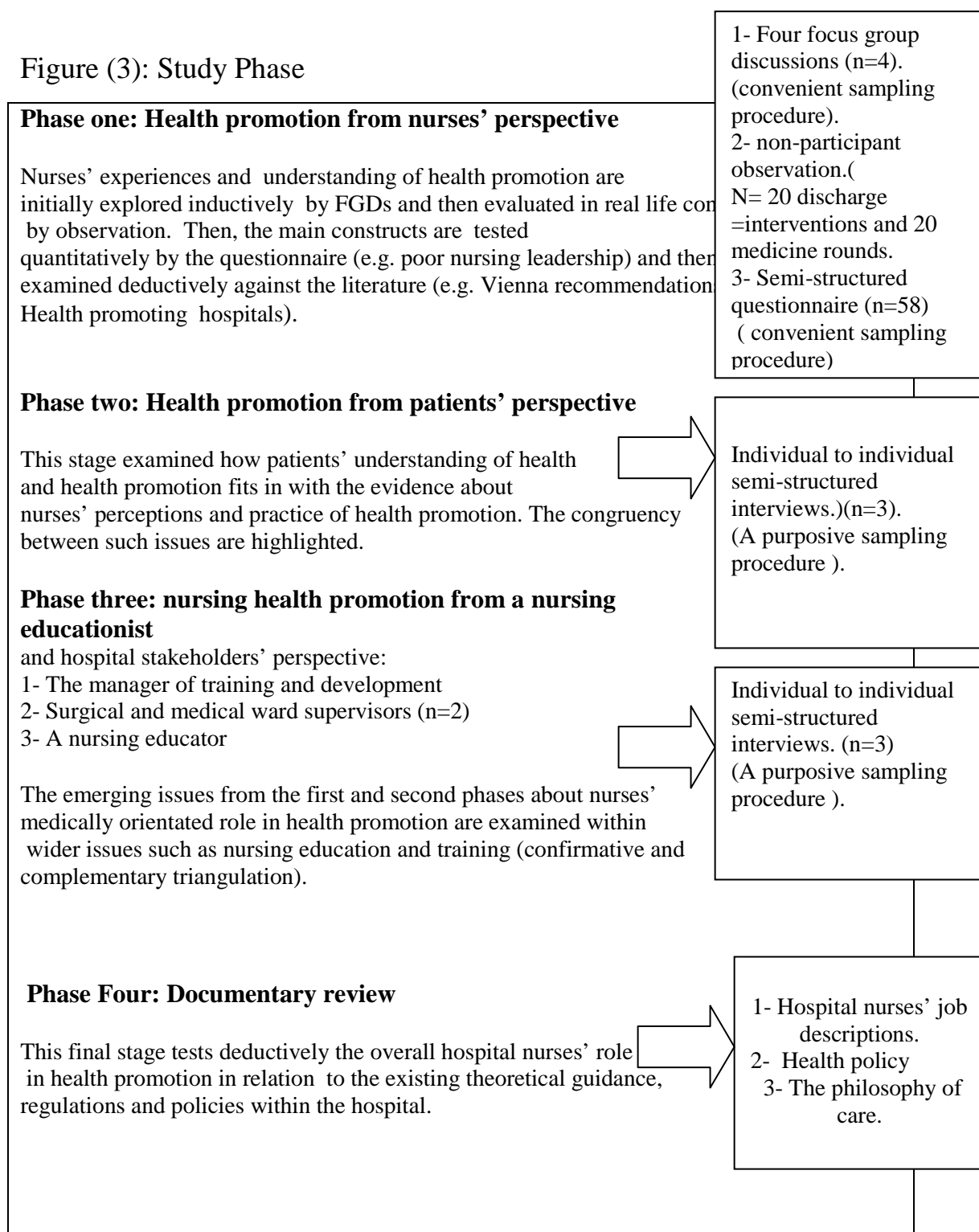
4.5 Research Phases

In order to minimize the complexity of voluminous data emanating from the triangulated research adopting the case study design, cross-sectional procedure has been used (McPherson and Leydon, 2002). This is congruent with the chronological model of combining qualitative and quantitative methods discussed previously. That is, it allows both study methods and understanding of the problem to progress over time.

As outlined in Figure (3), the current work is divided into four central phases but they are closely interrelated. The visual representation shows that comparative elements can be made between different phases and sub-phases. For example, nurses' understanding of health promotion can be examined from the group discussion, re-evaluated in "real-life context" by observation and the link between such an understanding and attitudes towards health promotion can be detected from the questionnaire data. This could be seen as an investigation of the problem at the micro level. At this level individual practice and cultural issues are better explored (Kim-Godwin et al, 2001).

As data were obtained from different nursing practice areas (surgical and medical wards), comparisons among such areas can be made to point out similarities and differences in practice within the whole organisation. The discussion now turns to explore each phase, its significance, methods and potential problems.

Figure (3): Study Phase



4.6 Health Promotion from Nurses' Perspective

The setting of case study includes surgical and medical wards (n=4). These areas were selected as, perhaps, patients are able to get involved in health promotion activities and to make their own decisions about lifestyle related issues. Indeed, there is a wide opportunity for the utilisation of empowerment approach to health promotion and identifying socio-economic and cultural issues pertinent to health (Maidwell, 1996, McBride, 2004). These settings therefore are suitable to health promotion components ranging from health education and disease prevention to socio-economic and empowering actions.

In order to capture holistically the role of hospital nurses in promoting patients' health and identifying those contributing factors involved, a number of methods were utilised. Although diverse methods were used (See below), their data were incorporated together for the purpose of achieving the research objectives. That is, each method has its own empirical contribution to make. A detailed discussion about each method and related issues of importance are given below.

4.6.1 Focus Group Discussions

To start at the beginning of data collection, exploratory methods were used and focus group discussions were arranged with nurses in surgical and medical wards.

Driven by the constructivist approach of this study, focus group discussions were used to identify constructs prior to the deductive testing of the problem under investigation. They reflect the epistemological commitment to a human-centred approach that stresses the importance of understanding how individuals think and act about the world they live in (Morgan, 1997). This epistemology is of relevance to hospital nurses' role in health promotion given its reliance on their skills and practice in relation to the health organisational world (Tones and Green, 2004, Whitehead, 2005).

Unlike individual-to-individual interviewing, focus group discussion is a more active and dynamic social discussion and thus a cumulative understanding of the identified problem can be achieved (Gillis and Jackson, 2002). That is nurses' interaction during the group discussion becomes a vital aspect of empirical contribution to the "development of shared stock of knowledge [and experience]" (Holestein and Gubrium, 1995, p.71).

Given the fact that nurses work together in a natural setting, focus group discussion could produce results derived from diverse experiences and thus more comprehensive and robust evidence can be reached. This is because the nature of interaction of the group allows participants to comment and build on and judge emerging issues (Gillham, 2000). As this cannot be attributed in individual-to-individual interviews and such discussions do not restrict the views sought, as in questionnaires (Burns and Grove, 2001), focus group discussion was considered as the most appropriate exploratory method to use. It was used first, not only for the aim of "discovery", but also for methodological benefits. Incorporating key narrative data found in focus group discussion into the content of the questionnaire enhanced both validity and reliability (Halcomb, et al, 2007).

As the study has included surgical and medical wards, more than a focus group discussion was needed to allow sufficient exploration. Indeed, conducting more than one focus group discussion will tend to increase the reliability of research data by detecting the consensus across the different groups (Morgan, 1997). In this context, issues emerging from one group can be considered in this study as triggers for the discussion in subsequent groups. That is, the current author thereby does not only uncover health promotion related issues but also creates the commonality of key points across groups.

However, there is no agreement about the suitable number of focus group discussion to be undertaken in health settings. Some authors (Barbour and Kitzinger, 1999, Morgan, 1997) suggest the use of saturation method in which focus group discussions continue until no new data emerge. The current research however rejects

this suggestion. Given the fact that focus group discussion is not the only method used with nurses, utilising the saturation procedure is beyond the timetable of the research.

Indeed, it is argued (Ressel et al, 2002) that when a complex phenomenon is involved, saturation procedure could lead to unlimited number of discussions making the analysis process a complex task. Hjelm et al (2005) resonates the above argument and postulates that an average number of three focus group discussions are adequate particularly in triangulated research. In order to ensure more coverage of the identified problem, four focus group discussions were used with hospital nurses. Three main issues associated with the focus group discussion in this study were identified (see below).

1- The Composition of Focus Group Discussion

In this study the composition of the focus group discussion has been addressed carefully. This is in order to enhance the interaction among participants and thus the rigour of data (Burns and Grove, 2001). The main issues include the differences in hierarchy levels among nurses. The more homogenous the members of the group are, the more likely they are to be voicing their views (Morgan, 1997). Likewise, it is argued that some participants could not feel comfortable to disagree with certain issues with the “boss” present as it may be “too professionally risky to disagree” (Macleod Clark et al, p. 144, 1996).

In light of this it was assumed that junior nurses would not be able to criticise without reservations the role of senior nurses in developing health promotion within a certain area of nursing practice. Similarly, arranging the discussion between senior nurses and hospital senior medical staff would lead to minimum interaction because of the possible power imbalance.

Although the heterogeneous groups could have a potentiality of gaining a wide range of views (Ressel et al, 2002), this proposal was rejected in this research. What is needed in a successful and dynamic focus group discussion is not only the diversity but importantly the “commonality” (Morgan, 1997). Considering these issues, a

homogenous focus group discussion was utilised. That is, junior and senior nurses had separate focus group discussions.

The first two discussions were arranged with junior nurses in surgical and medical wards. Each group was homogenous in terms of area of nursing practice (e.g. surgical ward nurses were together). This is in line with the case design principle stressing that each case within the case study needs to be examined separately initially and then to be compared with others in order to maximise the rigour of the work (Yin, 2003). The second focus group discussions were arranged with senior nurses from surgical and medical wards.

2- Sample Size and Sampling Procedure

The decision about the sample size was based in the growing debate about this issue. Although a larger sample size (more than 15) provides richer data, it is difficult to manage and ensure that all participants would contribute to the discussion (Barbour and Kitzinger, 1999). On the other hand, it was deemed that sample size if less than 4 would confine the full dynamic and diverse interaction among participants (Morgan, 1997). In consequence no sufficient coverage of the identified problem can be fulfilled which could badly affect the study validity. The current study included 4, 5, 6, 6 participants respectively for each group (see findings: Chapter 5) That is, the sample size is not too small to restrict the dynamic interaction among participants nor too large to manage (McLafferty 2004). How these participants were selected is illuminated below.

Initially, contact was made with hospital director and senior staff to aid the process of data collection. The study aim and ethical considerations such as anonymity and confidentiality were illuminated. It was assumed in advance that nurses had not experienced any health promotion activities. However, this causes no constrains, as the intention of focus group discussion is to elicit individual's diverse views and the perceptions about the phenomenon (Barbour and Kitzinger, 1999). It was planned to use a random selection procedure to minimize the selection bias. Unfortunately, this

was not possible. Hospital nurses were very busy at the time of data collection due to the lack of staff, annual holidays and maternity leave. Few numbers were available for establishing the sampling frame. Therefore the convenience sampling procedure was used. The current author was unknown to the hospital nurses with an exception to one who was excluded. This might have reduced the possibility of selection bias. However, the weakness of the above sampling procedure (eg. selection bias, representativeness of the sample) was compensated by other methods (e.g. questionnaires). On this basis, it can be argued that the sampling procedure will not threaten the overall rigour of this research. Hospitals nurses were selected after the handover (14:00) as many are accommodated within the hospital setting.

3- Necessary Preparations and the Format of the Discussion

The discussion was held in a hospital lecturing room that has good illumination and ventilation, upholstered chairs and space for realisation of the group activities (Ressel et al, (2002). Chairs were in a circle and the current author sat in a place where communicating with each other was possible. Before focus group discussions were undertaken, demographic information was collected (e.g. the length of experience).

The format of focus group discussions in the current study followed a “funnel structure”. Each discussion followed certain stages but was closely interrelated. The starting section is less structured in order to hear participants’ overall perspectives (e.g. the meaning of health). Whilst it is argued that nurses’ potential role in health promotion is influenced by their understanding of health and its broad determinants (Yoho and Ezeobele, 2002, Ewles and Simnett, 2004), this link was not fully examined by previous work (McBride, 1995, Irvine, 2007 and Whitehead, et al, 2008). Thus, it was important to examine how hospital nurses conceptualize both health and health promotion in the first place. To this end, a “brain storming” technique was used to stimulate the discussion and interaction among the participants (e.g. the meaning of health: what is it? no wrong and right answers: no one will be asked individually) (see appendix 1). On this basis, it is worth remembering that the current author was not interested in interviewing individuals simultaneously, but in a

focus group. That is, each a group discussion in this work was in its own right a unit of analysis. The current author who moderated the discussion did not display greater knowledge in health promotion than the participants. This is in order to enhance the flow of the discussion and not restrict the emergence of data (Morgan, 1997). The style of moderating the discussion was low control and high processes in which control over the discussion was minimal but the moderator ensures that all relevant issues are covered in depth (Burns and Grove, 2001).

In the middle section, the discussion was more structured in order to lead smoothly to the topic of interest (e.g. nurses' potential role in health promotion and their own perceptions and experiences). This area was not systematically understood in the international literature and specifically has not yet been examined in Jordan. Yet, such perceptions and experiences illuminate not only their potential in health promotion but also highlight their educational needs (Naidoo and Wills, 1998, Smith et al, 1999) and identify contributing factors (Cross, 2005, Irvine, 2007).

At the end of each discussion, a verbal summary with the help of participants was produced. It synthesised and confirmed significant themes found in the discussion. This ensured that the main areas of interest have been covered and verified by participants (Barbour and Kitzinger, 1999). Refreshments were distributed during the discussion in order to create a friendly and social environment. They were carefully selected to match nurses' health needs and in a way that did not disrupt the flow of the discussion. As the discussion was digitally recorded (see below), food that is noisy when eaten was avoided. However one of the focus group discussions was dominated by one nurse. Thus, the current author redirected the discussion in a polite way and ensured the interaction among all participants (e.g so what do the others think about this issue?). The dynamic interaction between participants was evident as agreements and disagreements about certain issues were elicited (See Findings Chapter 6). The mean time of conducting the focus group discussions was 50 minutes.

4- Recording the Data.

Further to receiving the permission of participants, data were collected using a digital voice recorder (Olympus VN). It allows events to be reviewed as often as is necessary. All focus group discussions were saved on different files in the recorder (A,B,C,D). Certain adjustments to the recorder were made to minimize any noise in the background. Then all files were transferred to the computer. Specialised software was used to control the quality and the speed of voices. For clearer understanding of the discussion, a headphone was used. However, recording the discussion does not pick up all verbal behaviour and record body movement (Polit et al, 2001). Thus, recording was accompanied by making hand notes of non-verbal behaviours (e.g shaking the head as a sign of agreement and disagreement). Reflected accounts of discussions were documented as soon as possible after each discussion.

5- Problems Associated with the Group Discussion

As with most research methods, focus group discussions pose some difficulties. Firstly, given the fact that its sample size is small, the generalisability of its data can be challenged (Gillis and Jackson, 2002). Likewise, it is argued that their data are firmly contextualised within a specific social situation (Morgan, 1997). That is, the discussion reflects a situational account of participants. However, within the context of this research's aims and methods, the above limitation is weak. The aim of the focus group discussions in this study is not to generalise findings - rather it attempts to gain in-depth insights into health promotion related issues in a dynamic and friendly way. Indeed, as more than one focus group discussion was carried out, cross-discussion analysis could lead to theoretical rather than statistical generalisation. Moreover, using a questionnaire in this research could counterbalance such a drawback. Secondly, the group influence could also affect the validity of data obtained in which some participants could agree with the majority of opinions. The above problems were addressed by moderator skills (e.g. encouraging all participants to express their views) and the composition of the group itself.

4.6.2 Observation

Whilst data derived from focus group discussions allow evidence to emerge about nurses' understanding of health promotion and their experiences, observation is the only way to examine such a phenomenon in practice (Gillis and Jackson, 2002).

Although their contributions are appreciated, earlier studies have been criticised due to the failure of using observation methods that capture what nurses do in the name of health promotion (McBride 1994, Maidwell, 1996, Cross, 2005, Irvine, 2007, Whitehead et al, 2008).

Employing observation in this study attempts to evaluate the gap between nurse's knowledge of health promotion and actual practice as it occurs in the natural setting. Potential factors that interfere with such practice, together with the nature of interaction between nurses and patients also were illuminated. That is, observation in this work offers valuable data from a first-hand perspective and thus it has an obvious relevance.

The literature offers three types of observations which have been evaluated for this work. This includes complete observer, complete participant and non-participant observation (Miles and Huberman, 1994). The first two types were judged as unsuitable. This is due to the fact that it would not be possible in a hospital setting to be completely detached from what is being observed and document observational data without both nurses' and patients' awareness. This could raise ethical issues (e.g. permission to undertake the observation). Whilst complete participant observation could minimise the Hawthorne effect (see below regarding this problem), it has been considered as unsuitable. For its full success, the current author needs to conceal his identity (McPherson and Leydon, 2002). Thus, once again, more ethical issues would emerge particularly when it comes to patients' privacy and confidentiality.

Culturally speaking, "hidden identities" in Jordan are often associated with "spying". This could lead to misunderstanding the whole aim of the current author's presence

at the hospital. Thus, participants' willingness to take part in the research will be in doubt. Finally, as the study involves different stages, it was unwise to conceal his identity in one stage and then reveal it in another (e.g. distributing the questionnaires).

As a result of this non-participant observation was adopted. Both nurses and patients were informed in advance about the purpose of research and were given consent prior to undertaking the observation. The current author seated himself in a suitable position to keep disruption at a minimum but allowed observation to be undertaken smoothly. In other words, the current author in this type of observation did not interact unless approached and the interaction was kept to a minimum whilst retaining social etiquette (Pretzilk, 1999).

Three forms of non-participant observation were identified in the literature – structured, semi-structured and unstructured (Turnok et al, 2001). The second form was used. This is because the literature does not offer adequate guidance into nurses' health promotion roles within the hospital setting. Thus, it is difficult to construct a standardised checklist to score and examine certain behaviour. Indeed, following a checklist, guided by pre-determined items, could constrain the emergence of the whole picture of practice in a natural setting (Mulhall, 2003).

Likewise, unstructured observation might be too broad to address the research questions and its data are complex to analyse. Thus, semi-structured observations were used. In line with the study constructivist approach, the reality of hospital nurses' practice was constructed in two ways. This is because a constructivist observation needs to expose different realities within its focus (Guba and Lincoln, 1994). Thus, initially, a picture of practice is exposed within its overall physical environment (e.g. the hospital and ward climate: noise, crowded areas) (Bowling, 1997). Then, specific issues related to health promotion can be tested against the existing literature and the evidence generated (e.g. communication approach between nurses and patients).

Whilst this type of observation has been marginalised in health promotion research (Cross, 2005, Whitehead, et al, 2008), it offers a valuable contribution to understand the climate in which health promotion is carried out (, Tones and Green, 2004, Irvine, 2007). More specifically, the importance of social and physical data relevant to the current research is elaborated by the analogy of jigsaw. The structured part of observation as well as data obtained from focus group discussions with nurses provide the pieces of the jigsaw and the pieces are then fitted into the “picture on the box” (Munhall, 2003).

That is, data about the climate of health promotion were analysed together with structured elements. This could enable further illumination about hospital nurses’ roles in health promotion to be elicited and light shed on contributing factors related to such a role. That is, whilst the semi-structured observation is flexible, it focuses on how data will be collected to meet the study aims.

4.6.2.1 Problems Associated with Observation

Although the observation method has key advantages in this research (see above), it suffers from limitations. The Hawthorne effect, in which nurses could change their behaviour while they are being observed, is a significant pitfall of this method. Although this problem cannot be completely eliminated in this research, at least taking certain measures could reduce it.

Some scholars (Polit et al, 2001, Gillis and Jackson, 2002) recommend that, in order to minimise the distortion of the situation under observation caused by the presence of the observer, a previous period of time needs to be spent in the field of observation. The above advocates argue that, whilst doing so allows the observer to be sensitised to the environment, it enables participants to be accommodated to the presence of the observer. Following this line of argument, the current author spent approximately one month in the areas where the observations were undertaken (e.g. surgical ward). That is, undertaking focus group discussions before observation offered a good opportunity for spending a significant time in the work field.

Nurses were informed in advance that observational data was completely confidential and would not be shared with their supervisors where they work. This could enable them to keep alterations in their practice and communication to a minimum level. A key point to make of relevance to the above discussion, is associated with the nature of this study methodology. It is argued (Pretzlik, 1999, Denzin and Lincoln, 2000) that triangulation is an effective way to maximise the validity of observational data.

For example, the observation method could be seen as complementary databases, which were examined within the context of data generated from other methods such as focus group discussions and the questionnaire. Therefore, evidence from the observation method about nurses' actual health promotion practice is not a straightforward process. It was verified and disputed by findings offered from other methods. Overall, in a setting like hospitals, most professionals, such as nurses, are busy maintaining behaviour radically different from normal (Mulhall, 2003). Whilst this was the case in the Jordanian hospital, no claims are made in this work suggesting that no Hawthorne effect has occurred.

1 - Access to the Participants and the Observation Process

Initially, a face-to-face contact was made with senior nurses and receptionists and related information about the research and ethical issues was provided. Ward Clerks were asked to inform the current author in advance (if possible) about expected patient discharge plans. With the help of nurses, only patients who are psychologically and physically able to take part in the research were invited for participation. Each patient and his or her allocated nurse were offered information (verbal and written) about the research and ethical issues of significance such as confidentiality and consent form (see ethical considerations section). They were informed that the aim of observation is to examine any related issues to health promotion rather than evaluate personally nurses' skills. The current author seated

himself in a location that minimised the distortion of what was being observed but without losing the picture about what went on. With both nurses' and patients' permission, the conversations between them were digitally recorded. Doing so could aid the analysis process by offering essential data about issues of significance related to communication skills and health promotion (e.g. listening, who dominates the discussion, empowerment). Reflective notes were made immediately at the hospital after each observation about the nature of interaction between nurses and patients, in particular body language (e.g. body gesture, eye contact and facial expressions) and the context of the interaction.

2- The Number of Observations

A total number of 40 observations were undertaken in surgical and medical wards. The observations included 10 discharge interventions in surgical wards (n=2) and the same number in medical wards (n=2). It is argued that discharge plans enable hospital nurses to act from a health promotion perspective as they need to offer support and knowledge to ensure patients remain independent and well at home (Smith and Cusack, 2006). That is, it is transitional and includes multidisciplinary work.

In addition, 10 observations of medicine rounds were undertaken in surgical wards and the same number in medical rounds. This time was suitable to explore patients cultural beliefs, family involvement and any element related to empowerment such as fostering independence. The above observations were carried out in different shift patterns in order to consider the workload which is likely to be intense in the morning.

Recently, the hospital has offered some nurses a 1 year diploma course in diabetes and patients' education. Accordingly, 4 encounters between diabetic nurses and patients were observed. Although the above observations are contextually different, they share some issues related to health promotion. For example, it was possible to explore the nature of communication approach between nurses and patients (e.g.

expert-led approach or partnership approach). The mean time for observing discharge interventions and medical rounds was about 4 and 7 minutes respectively. By contrast, the encounters between diabetic nurses and patients lasted from 25-40 minutes. The conversations between nurses and patients were recorded with the permission of patients and nurses. However, in one case a senior surgical nurse refused openly to record the conversation. Although all efforts were made to inform all participants about the confidentiality of this research, she preferred to take hand notes. Her decision was respected and hand notes about the observation were taken. Whilst no reason was given about her refusal to record the conversation, it was felt that she believed that the information would be shared with the nursing management. She asked many times if this research aimed at identifying the competency level of nurses. The participant was assured again about the confidentiality of this study and its aim. Although this was an individualised case, the current author kept this event in mind during data analysis. As shown in the findings chapter, there was a blaming culture against nurses at the ward level. Thus, what happened was useful in a way that contributed to the overall evidence about the working climate at ward level. This is explored fully in the discussion chapter.

4.6.3 Self-administered Questionnaire

Whilst focus group discussions and observations elicited empirical knowledge as to how health promotion is understood and practised by nurses, the generalisability of their findings could be debated. This is due to the small sample size of participants and observations used. Indeed, “group think” and socially desirable responses are key problems from which focus group discussions suffer (Morgan, 1997). In an attempt to overcome this distortion and to maximise the rigour of the current work, a self-administered questionnaire was used. This allows nurses’ understanding of health promotion and practice to be compared within the framework of different areas of nursing practice. Simply, as it was distributed to a larger group of nurses (see below), it is expected that a fuller picture about nurses’ health promotion roles would emerge from different settings. Whilst the questionnaire offers little about the

context in which responses are originated (Gillis and Jackson, 2002), it's anonymity in this research could encourage participants to provide honest answers. This could add significant weight to the data validity.

1- Questionnaire Construction

The questionnaire design involved five parts. The first part examined respondents' demographic data (e.g. sex, age and area of work). Secondly, through using the Likert scale (see below), the questionnaire attempts to examine quantitatively nurses' views towards health itself. Such views might shape their role in health promotion (Ewles and Simnett, 2004). Thirdly, a part of the questionnaire dealt with hospital nurses' views towards their role in health promotion within the hospital setting. So doing offers evidence about how nurses view health promotion based setting movement and thus affect their role (Whitehead, 2005).

The fourth part of the questionnaire was designed to shed light on contributing factors that could affect the development of nurses' roles in health promotion. This is in order to explore and test certain factors generated by focus group discussions and observations. The fifth part of the questionnaire attempted to investigate nurses' conceptual understanding of health promotion and health education (see Appendix 2). The questionnaire was semi-structured, sharing both flexibility and standardisation features. Consequently, quantitative data can be argued by qualitative materials that emerge concurrently from the same collection method (Gillham, 2000).

The construction of the questionnaire was largely guided by the Likert scale. It is argued (Oppenheim, 1992) that the reliability of such a scale tends to be high because of the greater range of answers permitted to respondents. The scale was based on 5 points, ranging from "Strongly agree to strongly disagree". A neutral point "I cannot decide" was included to avoid forcing respondents to express an accurate view towards certain items. In doing so this could minimise the problem referred to as "socially desirable answers".

In view of the issues raised by previous research and the reviewed literature, a pool of positive and negative statements about health promotion was created. A mixed number of such items was then distributed randomly to rule out the possibility of automatic agreement (Gillham, 2000). Double or triple-barrelled questions in the same item were avoided in order to enhance the reliability of the scale. Although the questionnaire is the popular method in health promotion research, the above issues have not been well addressed in the previous work (McBride, 1994, Cross, 2005). Therefore the low validity and reliability of tools used has threatened the rigour of drawn conclusions.

With this in mind, certain measures were undertaken to maximise the validity and reliability of the questionnaire. Initially, face validity was carried out with hospital nurses (n=10) to examine the extent to which the questionnaire content is of relevance to their health promotion role. Secondly, content validity was checked with a panel of experts (n=5) in health and health promotion areas. The panel included two professors in community medicine and three PhD holders in nursing and refugees' health. Whilst hospital nurses expressed no comments, the panel recommended the following item be included:

“I feel that it is not possible to promote the health of opposite sex”

Accordingly, the item was incorporated into the content of the questionnaire. It was noted that wards at the hospital were divided according to gender. Female nurses are located to female patients and some male patients. On the other hand, male nurses are allocated only to offer care to male patients. Thus, it was felt that the above item is of relevance to the system of delivery care.

With respect to reliability, it was not possible to use some measures such as a test/re-test procedure and compute the reliability coefficient. This is because the questionnaire is not highly structured to meet the criteria of such a procedure (Varricchio, 1997). It includes, as outlined above, open-ended questions and given their qualitative nature, a statistical scoring system cannot be applied. However, the

questionnaire was piloted with a convenience sample of nurses (n=10) in another hospital to ensure its clarity. This was coupled with using certain linguistic phrases obtained from previous methods of familiarity to participants. This could enhance the readability of the questionnaire and plausibly its reliability. Overall, minor changes were made to the layout of the questionnaire and to the clarity of the Likert scale items. The questionnaire was prepared using the English language as it is the language used in nursing education and often in communication among medical team members at the hospital. This was also reinforced by consulting nurses themselves as well as other Jordanian researchers. However, the language used was simple and complex English phrases were avoided. The current researcher was often available in the hospital for any questions.

2- Distributing the Questionnaire

Once the questionnaire was structured and test piloted, it was distributed to the nurses in surgical and medical wards (n= 84). To manage the possibility of a low response rate, different strategies were utilised. The questionnaire was kept as short as possible to increase the likelihood of participation (Polit et al, 2001). Also, the questionnaire was redistributed after a week to gain more response from those nurses who might be unable to participate due to varied factors such as lack of time. Nurses were instructed to put the completed questionnaire in the boxes provided on ward. Each questionnaire has a code and then a 10 Jordan Dinar incentive was given to the randomly selected participant.

4.7 Health Promotion from the Perspective of Patients

Focus group discussions (n=4) were arranged with patients. It is argued that health promotion and the health service in general need to incorporate patients' voices, which is better explored through utilising focus group discussions (Umaña-Taylor and Bámaca, 2004). Indeed, the key relevance of this method to hospital patients stems from the fact that focus group discussions allow data to be gathered and constructed from those with literacy problems, in particular among the Jordanian

elderly. As hospital patients may share similar experiences of nursing care, the interaction amongst them in a friendly and social environment could enable a more comprehensive picture about health promotion to emerge (McKinley et al, 1997). The method is indeed time efficient, as the group of patients was interviewed at the same time. Consequently, focus group discussions have “superiority” in this research over other methods such as individual-to-individual interviews and questionnaires.

The composition of focus group discussions with patients to some extent is different to those arranged with nurses in terms of homogeneity. The importance of homogenous groups has been discussed earlier (see 6.4.1). However, the problem here is not the hierarchy differences but rather gender issues related to Jordanian culture. Although it is argued (Sim, 1998) that involving men and women in a same group discussion could achieve a high level of comprehensiveness, this argument has been deemed as unsuitable.

In fact Morgan, (1997) asserts that men and women are likely to perceive the topic differently, particularly if they do not know each other. The author goes further and recommends that separate focus group discussions need to be undertaken. However, in addition to this reason, the current author with a Jordanian background has assumed that men could dominate the discussion. The fact is that Jordanian women for conservative cultural reasons might be unable to participate freely in the presence of men who could be seen as “strangers” to them. As a result, the dynamic interaction, which is central to the focus group discussion (Ressel et al, 2002) might be eliminated.

With the above discussion in mind, it was decided that homogeneity in terms of gender for the focus group discussion with patients is essential. Other factors such as age, ethnic background and marital status were considered as variables that enrich the group discussion. In each setting (surgical and medical wards) separate focus group discussions for men and women were arranged. That is, two discussions within each of the above settings were carried out.

A further cultural as well as methodological issue in relation to the moderation of discussions was addressed. The effect of moderator's gender on the views of opposite sex is highlighted by focus group literature (McKinley et al, 1997). Given that health promotion is a multi-dimensional issue, it was assumed that sensitive topics could be exposed during the discussion (e.g. sexual issues in relation to chronic illness). Thus, it was decided that the discussions be undertaken by a female moderator with female patients. The decision was also reinforced by the health care system in Jordan where female patients are largely looked after by female nurses. Undertaking the discussion by a female moderator therefore could minimise the group reservations which in turn could enhance the credibility of data.

In accordance with this, a staff nurse with a Master's degree, who was not known to female patients, was invited to undertake the discussions. Before doing so, the study and its objectives were discussed thoroughly with her. Then, a role-playing scenario was undertaken in the proposed discussion room to ensure that the moderator has been armed with the needed skills. For example, making sure of the full dynamic interaction among participants and not focusing on a certain individual either verbally or none verbally (e.g. eye contact).

The current researcher has moderated the focus group discussion with male patients. During the discussion cultural behaviours were considered. For example, the current author avoided a crossed knees posture as it is often taken as an impression of power and prestige among lay and elderly Jordanians. Indeed, the current author wore jeans and a T shirt instead of a suit. This could minimise the formality of discussion, as the latter form of dress is often associated with "boss looking" in Jordan. In this context, interviewing a group of individuals in this research is not a straightforward process. That is:

"interviewing skills are not simple motor skills like riding a bicycle, rather they involve a high order combination of observation, empathetic sensitivity and intellectual judgement" (Gorden, 1992, p7).

Other issues related to essential preparations for the discussion and the natural format of introducing the topic are similar to those outlined earlier with nurses (See section 4.6.1). Specifically, the format of focus group discussions with patients was guided by the funnel structure. It is argued (Ewles and Simnett, 2004, McBride, 2004) that patients' receptivity to health promotion is shaped by their understanding of health and health promotion. Thus, as a prerequisite for exploring their views towards hospital nurses' role in health promotion, patients' understanding of such concepts were initially explored using the "brainstorming" technique.

Advances in the conceptualisations of health among hospital nurses and patients have not yet been empirically matched together within a health promotion context (McBride, 2004, Cross, 2005, Casey, 2007). Yet the delivery of competent health promotion activities needs to be derived from evidence on how patients' experiences fit in with the role of nurses in this area (Yaoho and Ezeobele, 2002, McBride, 2004). In accordance with this, patients were asked to express their views towards their health promotion experiences in general and particularly those that might be linked to hospital nurses' role health promotion (see appendix: 5). At the end of each discussion, a verbal summary with the help of participants was produced.

4.7.1 Sample Size and the Sampling Procedure

Given the fact that nursing staff were known to patients, the sample of 12 patients was selected randomly from a list provided by the nurse in-charge. This was in order to rule out the possibility of selection bias. If the selected patient did not meet the eligible criteria (e.g. unable to be mobilised), another patient was selected. In one case, a patient was excluded from the study due to a history of mental illness (admitted for liver problems). It was felt that including him might affect the dynamic interaction among participants as well as the reliability of any health promotion experiences. Only patients who were hospitalised for at least a week were selected. This is in order to ensure that they have experienced significant encounters with nurses and thus offer in-depth data.

Patients were approached and an information sheet, together with the consent form, were given to them. Friendly and simple explanations were also offered. A focus group discussion was cancelled as only 3 participants attended the discussion. This was despite the fact that 10 participants agreed to take part in the research. The group discussion was rearranged in the next week. Eventually focus group discussions (n=2) with medical patients included 5 and 7 participants. On the other hand, focus group discussions (n=2) with surgical patients included 6 and 5 participants. Demographic information was collected before the discussions were undertaken in order to understand the characteristics of the samples and how they might affect the quality of data (e.g. the reason for admission).

Some issues were better covered in the third and fourth discussions in light of the first discussion's preliminary analysis. For example, how nursing staff deal with patients and its effect on the overall health promotion work.

Whilst, overall, participants enjoyed talking about their health needs and understanding of health promotion, there was a main problem in the focus group discussions with male patients. Although participants were informed that the entire group needs to contribute to the discussion, an elderly man kept dominating the discussion and making comparisons between issues of life in the sixties and today (e.g. the price of food and housing). Thus, the current author politely refocused the discussion and encouraged other participants to contribute to the discussion. After that, the dynamic interaction among participants was restored. The mean time of the discussions was about 40 minutes. This was enough to address research questions suitable for patients' health conditions and their commitments to welcome their visitors.

4.8 Nursing Health Promotion from the Perspective of a Nursing Educator and Hospital Stakeholders

Considerable literature exists debating nurses' role in health promotion (Whitehead, 1999, 2001, 2003 Kim et al, 2003) but there is a lack of systematic research

exposing the link between organizational culture and nursing education and their impact on the development of hospital nurses' role in health promotion. These issues were superficially examined in previous studies (McBride, 1994, Cross, 2005, Irvine, 2007, Whitehead et al, 2008). This thesis aims to contribute to the evidence base.

In this third phase the research attempts to address wider issues that might contribute to the development of hospital nurses' roles in health promotion. That is, management issues at ward level, the nature of nursing health promotion and health education curriculum and training opportunities in health promotion for hospital nurses. A purposive sample of hospital stakeholders, including the manager of training and development, surgical and medical ward supervisors (n=2) and a nursing educator was selected. As their number is more than 4, arranging a focus discussion was considered.

Although such a heterogeneous group could present diverse views as well as arguments about the problem under investigation, the idea of using focus group discussion was rejected. The power imbalance amongst participants could restrict their ability to participate freely without reservations. For example, ward supervisors might not be able to criticise openly the department of training and development at the hospital.

Using a questionnaire with them was also considered but once again it was rejected. Whilst anonymity could enhance the validity of data, the questionnaire could raise more questions than answers (Gillis and Jackson, 2002). Thus, an individual-to-individual method was adopted to further understand the context in which responses are created. Three forms of individual-to-individual interviews identified in the literature have been evaluated in the current research. This includes: structured, unstructured and semi-structured. The first two forms have been considered as inappropriate. It is acknowledged here that structured interviews guided by the positivist approach are reliable due to their standardisation (Polit et al 2001, Gordon and Felisher 2002) but their data are superficial (Burns and Grove, 2001) to the aim of this research. Likewise, whilst unstructured interviews offer richer data,

participants could fail to focus on the question asked. This results in longer interviews and some diversions from the focus of the interest.

In light of this, semi-structured interviews were employed within the constructivist approach. The primary goal of this method is qualitatively to assess relational contexts of relevance to nurses' role in health promotion (McIlveen et al., 2003). This includes not only issues within the hospital nurses' sphere (e.g. skills and attitudes) but also the social, organisational and educational contexts. That is, the reality of hospital nurses' role in health promotion is constructed and examined from the perspective of different contexts.

As shown above, the semi-structured interviews share the main advantages of structured and unstructured interviews i.e. flexibility and consistency. The key issues identified in the literature, together with those emerging from earlier methods, were integrated into interview schedules. This included questions about the health promotion activities at ward level, training opportunities for hospital nurses in general and nursing students' theoretical input about health promotion before qualification. (see Appendices 4, 5, 6 and 7). This sits well with the argument highlighting that the ward climate (Irvine, 2007) and the nature of nursing curriculum of health promotion are powerful forces that might shape the quality of nurses' health promotion work. (Smith, 1995a, 1999, McDonald, 1998).

Once a convenient time was determined with the above participants and signed consent forms were obtained, interviews were undertaken. Whilst interviews with surgical and medical supervisors and the manager of training and development were undertaken in the hospital, the interview with the nursing educator was undertaken at the University which is attached to the hospital. Interviews were digitally recorded and then the data were transcribed.

4.9 Documentary Review

Finally, as the nurses' health promotion roles could be affected by certain organisational documentation (Nawafleh et al, 2005) it was decided therefore to review hospital nurses' job descriptions, health policies and the philosophy of care, i.e. the extent to which hospital nurses' roles in health are affected by the available documents in the hospitals.

4.10 Ethical Considerations of the Whole Research

Given the fact that different methods were used in the study, a number of ethical issues were addressed. Some issues have already been highlighted in the data collection process (e.g. consent form). More specifically, as the study was undertaken abroad, the proposal was approved twice. Whilst the first approval was granted from the Ethics Research Committee at QMU, the second was secured from the Research Committee at the Jordanian hospital.

All participants were assured that this research was confidential and there was no personal risk involved. In addition to the information sheet about the study, all participants were given a copy of the informed consent prior to participating in the study. The signed consent form was then obtained from each participant. They were assured that participation in this study was entirely voluntary and that they could withdraw at any time.

Patients were assured that refusing to take part in the study would not affect in any way the quality of care provided to them. All the participants were informed that they had the right to accept or to refuse recording of their discussions and interviews. Generally, the confidentiality was assured by replacing identified names with codes.

The participants were informed that the study's quantitative data would be statistically analysed and the qualitative data would be anonymously categorized and no identity would be revealed. Moreover, they were advised not to write their names

on the questionnaire in order to achieve a high level of anonymity. The current author was the only person who had the completed questionnaire, transcribed data and the digital recorder. All of these were kept in a locked file box in a secure office. At the completion of the study, the outcomes and results were reported as group data.

At the time of data collection however some other ethical issues had emerged in the workfield. Although the researcher emphasised the confidentiality of data, the manager the medical wards asked if some information could be given to her about the quality of overall care. The aim was to improve care and to identify those who need further training and supervision. As this was ethically unsound, the request was politely denied. It was felt that offering her the requested information at this stage could affect negatively the trust between the researcher and nurses. As a result, they could refuse participation in the following phases of the research.

Indeed, it is worth considering that if nurses had doubts about the confidentiality of research, the validity of data could be compromised. This is due to the possibility of over-exaggerating the importance of their health promotion role in terms of theory and practice. The researcher informed charge nurses that some information would be provided later about emanating findings as a whole without violating the anonymity and confidentiality.

A further ethical issue was contemplated. Whilst the primary role is to collect data using different methods, in one case the role has changed. During undertaking observation at the time of medical rounds, a patient with epilepsy suffered from severe seizures. As a result the observation was stopped and the focus turned to helping the patient rather than collecting data. Given the researcher's experience in dealing with neurological cases, the equipment needed (e.g. oxygen mask, IV set.) were brought from the ward store. It was felt that being a "helper" needed to take priority over being a researcher as long as the involvement would not pose a threat to the life of the patient.

4.11 Data Analysis

As methods triangulation strategy was employed in this research, the analysis process needs to contemplate issues of significance to each method. Initially, the qualitative and quantitative were separated and handled in a traditional manner as dictated by methodological considerations. That is, statistical analysis for quantitative data and thematic analysis dealt with qualitative materials.

4.11.1 Quantitative Data Analysis

The quantitative data elicited by the questionnaire was analysed using the SPSS (version 13). Three different levels of data measurements were elicited by the questionnaire. This included nominal (e.g. gender) interval (e.g. the age group) and ordinal data created by the Likert scale.

Having coded the questionnaire's demographic data, descriptive statistics were used (e.g. mean, percentages and standard deviation). Considering their nature, each item included in the Likert scale was scored. Whilst positive items were scored from 5-1, negative items were reversely scored from 1-5. Individual analysis of items was then undertaken. Summing up scores was not performed. The total score of Likert scale lacks reproducibility (Buckingham and Saunders, 2004). This means that the same total score may be different in many different ways. Simply, two or more identical scores may have totally different meanings. Further, given that a triangulation procedure was used, it was decided that individual analysis of items could allow better reinforcing of otherwise certain emerging themes from other methods. That is, in this study the pattern of response for each item was more important than the total score.

Using the mean value, the sample was divided into two groups. Thus the half of the sample with scores higher than mean would constitute those participants who hold more positive views about hospital nurses' roles in health promotion. In contrast, those with the scores below the median will be considered as holding more

pessimistic views. Two groups were then contrasted by using the demographic variables to identify those who may be associated with holding positive or negative views. To test for the statistical significance of the ordinal data, the Spearman's products as well as Chi-square were used to examine the correlation between variables. Where P values are to be calculated, a two-tailed test of significance was used as it was not possible to recognise whether participants would give a positive or negative response.

With respect to open-ended questions, a thematic analysis was used. This is discussed in detail below. Meanwhile, it is essential to point out that coding the questionnaire's open-end questions is much more complex than close-ended. This is due to the nature of qualitative data and the wide range of responses that participants could offer. Consequently, all responses were scanned initially to identify the key themes and the commonality between them. Then, identified themes were coded to enter into SPSS for further analysis.

4.11.2 Qualitative Data Analysis

Initially it was planned to manage qualitative data using N-Vivo (2). However, due to practical difficulties in accessing the programme, only a few transcripts were analysed using the above method. Generally, the transcripts were largely analysed using the thematic analysis (filing and colour index method - see below). Whilst N-Vivo was time efficient in terms of coding and producing coding reports, the current author felt "closer to the data" using the filing method. This was similar to other researchers (Dean and Sharp, 2006).

However, regardless of the method used for analysing qualitative data, it is important to be familiar with the thematic analysis process (Gillis, A and Jackson, 2002). It studies thoroughly the individual's experience, attitudes, beliefs and behaviour by gathering all segments of data to develop an overall picture about the problem under investigation (Lambert and West, 2002). Inductive approach in this study aims to

explore the world of hospital nurses' roles in health promotion from different perspectives. This includes nurses, patients, the nursing educator and hospital stakeholders.

Yet using a purely qualitative analysis approach was deemed as inept. The reason for this is that semi-structured interviews as well as the semi-structured questionnaire involved a number of close-ended questions. Their data therefore could be addressed by a degree of quantification. Indeed, given that more than one focus group discussion was undertaken in this work, it is recommended (Morgan, 1997, McLafferty 2004) that some quantification would be beneficial for comparison purposes. However, using such an enumeration procedure is not free from criticism. Counting certain themes found in the text could contradict the principle of qualitative data focusing on ideas rather than numbers (Polit et al, 2001). Whilst this is borne in mind, the former criticism is weakened as monitoring the occurrence and the sequence of qualitative events is not a "counting game" (Gillis and Jackson, 2002). Instead, enumeration of qualitative data could allow a degree of concurrence to be verified and compared with key issues created by other qualitative methods (Farmer et al, 2006).

The second criticism of enumeration of qualitative data lies in the possibility of decontextualising their nature. This threat was also addressed by carefully reporting as much as possible of the information about the context of qualitative data in which they were generated and organised. Taking these considerations together, it was decided that a degree of quantifying be introduced to qualitative data analysis.

Whilst using only the qualitative analysis approach was rejected, so was the pure use of quantification. Qualitative methods, such as focus group discussions, aim to understand in depth a certain complex phenomenon that cannot be fully explored by numbers (McLafferty 2004). Failure to do so could create a conflicting gap between the method and its paradigmatic principles as explained earlier in this chapter.

Therefore both qualitative and quantitative approaches were used. This could not only allow a comprehensive understanding of nurses' health promotion roles to emerge but it could also enable the researcher to monitor the representativeness or dominance of certain respondents' categories.

The analysis process involved two key stages. Firstly, manuscripts created by each method were analysed separately. Then, all sets of data emanating from diverse resources were examined in relation to a certain theme. Whilst thematic analysis suits different sorts of qualitative data, there are some issues to be addressed in relation to each method. As discussed in Chapters 2 & 3, earlier research guided by a qualitative approach has been criticised because of the exclusive focus on findings rather than on analytic processes. Consequently, judging the rigour of reported findings is a difficult task. To avoid this in the current study, a detailed account of how thematic analysis was carried out, together with certain measures to resolve potential problems, are given below.

4.11.3 Thematic Analysis Procedure

Each manuscript was transcribed verbatim into a separate identified folder. The digitally recorded focus discussions or individual interviews were re-played many times to ensure the adequate understanding of obtained data. As a standard digital recorder was used, it was possible to minimise the background noise and change the sound tones to maximise the clarity of voices.

The manuscripts were read through frequently, to become familiar with the overall picture of data (deductive analysis). That is, this approach was used to discern an overall and fundamental meaning of experiences (Hall, 2004). Then, line by line a search of manuscripts was undertaken to scan central themes (e.g. how do nurses understand the meaning of health promotion?). This included repeated ideas or statements "that say something" (Brunard, 1991). This process was accompanied by

making notes about each manuscript using different colours for different themes (e.g. green = the meaning of health promotion, red = the meaning of health).

Once again the manuscript was re-read to check that common themes were really common in the manuscripts. Indeed, so doing allowed the current author to become immersed in the data and thus the “life world” of participants (Gillis and Jackson, 2002). Once the current author has become aware of the main issues found, as many headings as necessary were highlighted. Irrelevant materials which are referred to as “dross” (Brunard, 1991) were identified and excluded from the analysis (e.g. talking in a detailed way about the housing prices). Whilst this could involve bias because of the hazard of subjective decisions regarding relevant materials, it aids the development of data that are specifically of significance to the work objectives (Miles and Huberman, 1994). However, if in doubt about what to exclude from analysis, both relevant literatures together with the current work objectives were examined. Thus, the possibility of subjective decisions, regarding what is relevant or otherwise, was kept to a minimum. Eventually, irrelevant materials were kept in mind at the end of data analysis to see if they fitted in with the overall picture of the data emerging.

Once the main themes were highlighted, a category system was created for each manuscript (e.g. Category One: all themes about the meaning of health and related extracts). Initially, as many categories as possible were generated and materials of relevance were linked accordingly. Then the number of categories was reduced (collapsing stage) i.e. some of the ones that have similar contents (Brunard, 1991). Once the final version of categories was finalised, each of them was examined within the context of each question reported in the interview schedule.

As qualitative analysis is an ongoing and dynamic process, during the writing up phase, if there is some doubt about certain findings, the current author checks the manuscript to ensure the credibility of analysis.

The extent to which certain themes are based on “real data” were re-checked and reinforced by examples. A Jordanian research colleague (PhD student) in the UK was asked to produce another list of categories without seeing the first one (2 transcripts). This introduced the reliability element to the categorisation process.

Given the nature of qualitative data and the complexity of its quantification, an inter-rater reliability coefficient was not computed. Instead, both researchers discussed the given category to examine the level of agreement or otherwise. The discussion was informed by some examples of significance reported by participants. As a result, some changes were made to the category label as well as the related content.

However, in case the discussion between the independent researchers showed a remarkable difference, two interventions were utilised. Firstly, each researcher needed to offer justifications for a certain category by giving extracts from the original manuscript as “live evidence”. Before data were collected, it was anticipated in advance that, if the disagreement has not been resolved, a third researcher will be involved in analysing specific manuscripts and then all researchers will discuss a debated issue together until a high degree of agreement is reached. In the current study, only the first measure was used as the disagreement was resolved after further information was given about the study’s theoretical background. For example, the PhD student referred to protecting health from disease as a “physical view of health”. The current researcher explained that this will be categorised as a medical view of health in order to minimise the conceptual ambiguity highlighted in Chapter (2).

Whilst measures were undertaken to enhance the credibility of data, it is unwise to claim that bias was entirely eradicated in this work. Arguably, the only way of analysing qualitative materials without manipulation would be to offer the manuscripts whole and unanalysed, so readers themselves could judge them (Brunard, 1991, Miles and Huberman, 1994). However, practically this is not possible given the amount of data created by this research, coupled with difficulties in understanding their contents, particularly those linked to cultural issues.

The above thematic procedure was applied to documentary reviews, interviews (n=4), focus group discussions (n=8) and observational data. However, because of their nature and aims, the data of the latter two methods required further analytical procedures. This is illuminated in the next two sections.

1- Focus Group Discussions

Discussing the debate about analysing the data of focus group discussions, Barbour and Kitzinger (1999) argue that such data could be basically analysed as other qualitative self reported data. Whilst in one respect this could be true, given their qualitative nature, it is crucial to maintain a sense of the whole group within the analysis in this research. That is, it is the group that is the unit of analysis and not individuals within the group (McLafferty 2004). Subsequently, certain strategies were undertaken whilst the discussion was in progress and after the data were collected.

Careful attention was paid to obvious ambiguities, latent disagreement and “unfinished business” that arose in the course of the group (Barbour and Kitzinger, 1999). In addition to thematic analysis procedure outlined above, the transcript was read through at least three times. This was in order to establish where there was group consensus on an identified issue and to distinguish individual’s opinions expressed supporting or otherwise the group. At the same time, the transcripts were analysed with this in mind and an overview grid was used to provide a synthesis of the emerging themes.

Finally, during analysis, data emanating from group discussions involved examples of the discursive nature of the method by reporting two or more participants in any extracts rather than focusing on an isolated excerpt offered by a certain individual. Although the above strategies are critical for a systematic analysis of focus group discussions (Umaña-Taylor and Bámaca, 2004), earlier qualitative work paid little attention to the above points and offered inadequate descriptions on how the data of

focus group discussions were analysed (See Chapters 2 & 3: Maidwell, 1996, Hjelm et al, 2005). This has raised concerns about the credibility of conclusions generated from such a dynamic research method.

2- Observational Data

Whilst data from interviews, questionnaires and focus group discussions offer a theoretical input into nurses' roles in health promotion, observation aims to capture the whole picture about such a role in practice. Plausibly, data obtained by observation would ascertain whether what nurses' say they do is what they actually do in reality. However, in this study both "accounts" are valid in their own right and just represent different perspectives on the data. Accordingly, observations could serve as a complementary database for the above methods.

As the observation was semi-structured, thematic analysis as well as a degree of quantification was applied to its data. However, given the "live" and dynamic nature of observational data, activity analysis also was adopted. This means that observational manuscripts were guided and structured by asking key questions such as What was the context? What were nurses doing? What sorts of activities (in the name of health promotion) were carried out? Were there any problems during the interaction between nurses and patients? Who was involved in the interaction (e.g. patients alone)? Who did dominate the interaction? Did nurses identify patients' health promotion needs? How did the interactions fit in with the theoretical background of this study reported in Chapters 2 and 3.

As the focus of the current work is on health promotion with its diverse components, within the hospital setting, data were analysed and categorised in view of the following formula identified by (Tones and Green, 2004).

Health promotion = Health education + Disease prevention + Health policy
Indeed, this was accompanied by taking into account Vienna's recommendations (WHO, 1997) for effective health promoting hospitals (HPH). The recommendations

were slightly modified to meet the current study nursing focus. They were turned into a questions format (as seen below):

- I. Do nurses offer a holistic focus on health activities that improve patients overall health status and not only focusing on medical health?
- II. Are patients' socio and economic factors considered when general care is planned and provided?
- III. Are nurses able to establish communication channels outside the hospital (e.g. with other organisations) to meet certain patients' health needs?
- IV. Do nurses have a potential to affect health policy (e.g. banning smoking in the hospital)?

Such questions could allow the pattern of health promotion practice to emerge within a certain area. Whilst it is acknowledged that the complete elimination of observational bias is not possible (as observational data were collected directly through human senses such as seeing and hearing), the validity and reliability could be kept to a maximum for measures utilised in this research (see observation section).

As the study is not only informed by the observation method, a detailed conversational analysis of the interaction between nurses and patients was rejected. This is because the nature of such interactions makes it challenging to identify the individual's own contribution to a certain encounter. Thus, it was deemed that the micro-analysis of each conversation is not the aim and beyond the time table of this work. Instead, an endeavour was made to be familiar with the main content of conversation. The full conversations between nurses and patients were played back many times to illuminate the way in which health promotion could be practised. The kinds of health promotion activities were highlighted in line with questions outlined above. The nature of approach used during the interaction with patients (e.g. nurses dominate the conversation or the interaction was collaborative) was also determined.

4.11.4 Trustworthiness of Qualitative Data

Given that the current work is mainly informed by qualitative materials, trustworthiness was established. This research's rigorous criterion has not been well addressed in earlier work (See Chapters 2 & 3: Yaoho and Ezeobele, 2002, Hjelm et al, 2005, Whitehead et al, 2008). Accordingly, whilst their findings are acknowledged, the robustness of their conclusions is open to debate. With such pitfalls in mind, the elements of trustworthiness in the current research such as credibility, dependability, and transferability, which is referred to in quantitative research as generalisability, were taken into account. These, together with proposed measures to achieve each of them, are respectively discussed below.

It is argued (Burns and Grove, 2001, Polit et al, 2001) that in order to enhance the credibility of qualitative data analysis, prolonged engagement with participants and their environment is needed. In accordance with this, before the data collection process took place, the current author spent significant time in the hospital informally talking with potential participants. On many occasions he had coffee with nurses and chatted with some patients on the balcony of the hospital about general topics. The overall research aim and related ethical issues were discussed with them but no detailed information was given about research methods and health promotion in hospitals. Spending significant time in this setting and with potential participants could enable in-depth understanding of culture and language and could aid the development of trust and rapport with them (Gillis and Jackson, 2002). Consequently, more honest responses could be obtained from them and more valid interpretations of their views could be accomplished.

Additionally, the credibility of the qualitative data was also maximised by the nature of methodology itself. By utilising methods triangulation strategy in this study, the level of convergence among different sets of data generated by diverse methods can be checked. For example, in order to draw conclusive evidence about nurses' understanding of health promotion, analysis processes incorporated different data sets from focus group discussions and observations of relevance to such an

understanding. Doing so could not only achieve completeness but also enable the “convergence” to take place during analysis. Therefore, the true information can be distinguished from those with errors.

Finally, the credibility of qualitative data was addressed by members checking the data. This was accomplished when data were collected as well as by later asking some nurses (n=11) and patients (n=5) to check the consistency between the transcribed data and with what was really reported by them. As a result, semantic validity could also be enhanced as participants could judge whether the language and phrases used had a similar meaning to them. This is a fundamental point in this research as the current author from the south of Jordan is not familiar with the meaning of some Arabic phrases used in other parts, especially in the north. Thus, the possibility of misinterpretations of certain phrases was kept to a minimum and thus the risk of obtaining low credibility of data could be decreased.

With respect to dependability, as reported in thematic analysis, it was achieved by inviting a research colleague to categorise independently a random selection of manuscripts. The current author and the independent researcher then discussed the agreement or disagreement of certain themes found in the manuscript. Some samples of the coding and emerging themes were discussed with the supervisors of this work for guidance and debate.

The research does not claim statistical generalisability because of the nature of case studies and qualitative methods which focus on in-depth understanding and illumination of an identified problem. Rather, the meaning and ideology of transferability was utilised. Thus, attempts were made to examine the extent to which findings from data could be applicable to other hospitals. That is, although nurses’ roles in promoting patients’ health could not be identical, there are some commonalities which might be of relevance.

What is advised by qualitative analysis scholars (Miles and Huberman, 1994, Polit et al, 2002) - a sufficient descriptive account of findings were given in this thesis. A

thorough account of transactions and processes observed during the investigation were offered. Any unexpected problems that occurred were also documented (see Ethical Issues Sections and problems with focus group discussions). This would enable the readers themselves to judge the applicability of the findings to other contexts. In other words, contextual similarities could be outlined and thus a level of transferability could be gained. In conclusion, given the adherence to the above measures it can be argued that the trustworthiness of this work is maximised

Chapter Five: Demographic Data of Participants

5.1 Response Rate of the Questionnaire and Data Processing

Initially, of all questionnaires (n=76) conveniently distributed by the researcher, 28 had been returned. This resulted in an achievement of a poor response rate of 37%. In the following two weeks, two follow up contacts were made with ward nurses regarding the importance of their participation in this research. Flyers were left in each ward to remind them to return the completed questionnaires. This has resulted in getting a further total of 32 questionnaires. Due to the extensive missing data, two questionnaires were excluded from the analysis. The final response rate therefore is 72% (n=58). Generally, this is considered a satisfactory response rate (Gillis and Jackson, 2002).

There is, however, a degree of uncertainty about those who did not respond. That is, the threat of non-response bias. As the questionnaire was anonymous, it was not possible to identify the characteristics of those who did not respond. Nevertheless, as the researcher approached similar numbers of nurses in surgical and medical wards, surgical nurses returned fewer numbers of the questionnaires. This could be due to the lack of time, busy shifts and perhaps lack of interest. On this basis, it would appear that non-respondents work in surgical wards.

Whilst the threat of non-response bias cannot be eliminated, it could be minimised by the good overall response rate the study achieved (Oppenheim, 1992). Further, as the total number of nurses in surgical and medical wards is 84, a number of 58 would represent 68% of the total target population. This includes non-respondents (18%, n=18) as well as those who have not been approached (n=8) for different reasons (e.g. maternity leave, sick leave and annual holiday). Non-respondents therefore represent statistically a small proportion of the targeted population. This would not affect seriously the external validity of the findings within the case study design (Yin, 2003). As explained in Chapter 4, the aim of the constructivist case study is to understand, test constructs and emphasise the complex and uniqueness of the case rather than to generalize findings (Creswell, 1998).

A further important point needs to be attached to the above discussion. It is worth remembering that the findings derived from the completion of the questionnaire were used as a complementary rather than primary database in this work. As outlined in the previous chapter, quantitative data were used to confirm or otherwise the emanating themes from other methods and thus strengthen the robustness of the study. That is, as the study is not only informed by emanating data from the questionnaire, limitations could be compensated by data offered by other methods.

Once the completed questionnaires had been collected, data were coded and prepared for analysis using SPSS version 13. As outlined below, data were identified in order to aid the selection of the suitable statistical test.

Nominal data -----	Sex, workplace and education
Ordinal data-----	Likert scale items
Ratio data -----	Age and experience.

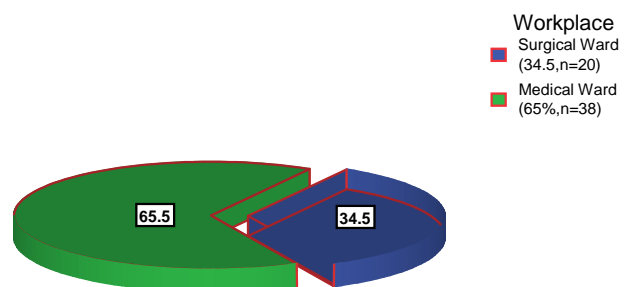
Then statistical tests were carried out. Whilst descriptive statistics were used to examine frequencies of each variable, Chi-square and Pearson's product were used to detect the relationship between variables. All statistical tests were carried out at the significance level of $P < 0.05$ (two-tailed).

5.2 Demographic Data of Respondents from the Questionnaire

The mean age of respondents was 29 years (SD =5 years). On the other hand, the mean experience was 6 years (SD =4 years). Of all respondents (n=58), it was found that the sample was dominated by females (60%, n=35). Nevertheless, it would appear that the number of male nurses (40%, n=23) in the study is higher than those previous studies (McBride, 1994, Cross, 2005). In addition to the possible difference in the sample size, the current economic situation in Jordan could explain the findings. During data collection, the nursing manager of training and development as well as a nursing educationist pointed out that a lot of men have started joining the nursing profession especially within the last 6 years. Given the increasing unemployment rate in Jordan coupled with high living costs following the recent

Iraqi conflict, having a degree in nursing is a reasonable solution to address economic constraints. Qualified nurses in Jordan have better recruitment opportunities and their wages are better than other professions (e.g. teachers and engineers). The analysis has shown that the vast majority of respondents (85%, n=49) had BSc degrees in nursing. By contrast, only 15% (n=9) held a diploma degree. These findings are not unexpected given the growing BSc programmes in Jordan within the last decade (see the study context). As shown below, of all respondents (n=58), the majority (65.5%, n=38) work in medical wards. This might be explained by different reasons. Whilst similar numbers of surgical and medical nurses have been approached, it would appear that medical nurses were more motivated to take part in the research. Moreover, observational data would indicate that the workload in surgical wards is higher in terms of the number of patients, admissions and discharges. Reasonably, under time pressure, surgical nurses may not have had as sufficient time to complete the questionnaire as their counterparts. It seems also that medical nurses might have better opportunities to get involved in health promotion work due to the nature of cases they deal with. For example, unlike surgical patients, medical patients often suffer from chronic problems which need frequent admissions. Thus, this might offer nurses more time to explore concerns and needs and deliver health promotion. This will be debated further in the findings.

Pie chart (1): The number and percent of respondents in surgical and medical wards



5.3 The Profile of Surgical and Medical Nurses

The focus group discussion with junior nurses involved 4 participants. In contrast, 6 participants joined the focus group with senior surgical nurses. All of them had a BSc degree in nursing with the exception of one senior nurse who had a diploma degree.

Other demographic data about participants are given in Table (1).

Table (1) The Profile of Surgical and Medical Nurses

The type of Focus group discussion	Number of Participants	Gender of Participants	The mean length of experience
Focus Group Discussions with Junior Surgical Nurses	4	2 males 2 females	1.5 years
Focus Group Discussions with Senior Surgical Nurses	6	All females	7 years
Focus Group Discussions with Junior Medical Nurses	5	2 males 3 females	1.2
Focus Group Discussions with Senior Medical Nurses	6	2 males 4 females	6.5 years

5.4 The Profile of Patients

Four focus group discussions with patients were undertaken. The overall characteristics of participants are given in table (2).

Table (2): The profile of Patients

The type of focus group discussions	The number of participants	The mean age/years	The main reason for admission
Focus group discussion with medical male patients	5	37	Chronic asthma, wound infection, blood coagulation problems, chronic obstruction, pulmonary disease and diabetes
Focus group discussion with medical female patients	7	49	Hypertension and diabetes (2), peptic ulcer, chronic asthma, Hepatitis A, heart problems, lung problems.
Focus group with surgical male patients	6	45	Appendicitis (n=2), wound infection, diabetic ulcerations, intestinal obstruction, colostomy problems.
Focus group with surgical female patients	5	47	Severe chest infection, diabetes, appendicitis, lower GI bleeding, bladder problems, liver trauma

Chapter Six: Hospital Nurses' and Patients' Understanding of Health and Health Promotion.

6.1 Introduction

This chapter aims to present findings pertinent to the concept of health held by participants. Whilst the first part of this chapter deals with the way hospital nurses understand health, the second part addresses patients' own images of health and related needs. As the analysis shows some differences in the understanding of health among surgical and medical nurses, it was decided to present themes according to the area of practice. .

6.2 Images of Understanding Health among Surgical and Medical Nurses

The overall hospital nurses' views about health were collected by the questionnaire. These views are described below.

Table (3): Nurse Respondents' Views towards Health

Items	Strongly Agree	Agree	Cannot decide	Disagree	Strongly Disagree	Total	The mean scores
Health is freedom from illness	59%,n=34	29%,n=17	-----	3%,n=2	9%,n=5	100%,n=58	3.7
Understanding health holistically is important for effective care	59%,n=34	33%,n=19	-----	9%,n=5	-----	100%,n=58	4.4
God controls our health	53%,n=31	40%,n=23	6%,n=3	2%,n=1	-----	100%,n=58	4.4

Of all respondents (n=58), just slightly more than half of them (59%, n= 34) strongly agree with the item reporting that "health is freedom from illness". Likewise, 59%

(n=34) strongly support the item stating that the holistic understanding of health is important for effective care. Whilst viewing health from a medical perspective is popular, it seems that respondents felt that effective care needs to be informed by a holistic view of health. However, although the questionnaire was pilot tested, respondents in this study might have failed to understand the meaning of “holistic health”. Alternatively, they could have attempted to idealise their response to intuitively meet the researcher’s expectations (giving socially desirable answers).

However, when these items were statistically correlated with the demographic variables, it was found that surgical nurses agreed more than medical nurses with the item “Health is freedom from illness”. Whilst it is acknowledged that the majority of respondents (65.5%, n=38) work in medical wards, it seems that surgical nurses might be guided more by the medical model of health than their counterparts in surgical wards. This might be due to the acute cases that need immediate medical actions to save lives and prevent disability (Davis, 1995). On the other hand, due to the length of hospitalisation of patients on medical wards and their chronic problems, nurses might be more cognisant of other aspects of health such as social and psychological. However, as presented in the sections below, in general respondents’ understanding of health promotion is largely guided by the ideology of the medical model of health.

In response to the item stating that “God controls our health”, approximately half of respondents (53% n=31) offer strong agreement. It should be noted that the mean score of this item is 4.4. As a 5 point Likert scale was used, 3 is the mean score of the items. Given the value of 4.4, the statement therefore achieved strong agreement. The same statistical value also was found in the item stating that “understanding health holistically is important for effective care”.

Statistically significant and mild positive correlation was found between the item “God controls our health” and experience (Spearman's $\rho = +0.24$, $P = .034$). Similarly, positive but stronger correlation was found between age and experience (Pearson correlation = $+0.714$, $P = P < .001$). In this context, it could be argued that the

older the respondents are, the more likely they are to give attention to spiritual beliefs when it comes to health. This echoes findings from Mexican studies suggesting that spiritual beliefs are correlated positively with age (Maddox,1999, Yoho and Ezeobele, 2002).

Nevertheless, given the mild correlation between the item and experience as well as the absence of data about the nature of respondents' spiritual beliefs, the findings need to be viewed with caution. It is also worth emphasising that correlation does not mean causation. Perhaps other unexamined variables could have led to the findings. This issue is examined in view of emerging qualitative data from focus group discussions (see below). Data pertaining to the way nurses understand health were elicited by different questions included in the discussion schedule. Firstly, through using brainstorm techniques, they were asked to keep all images in mind about the meaning of health. They were asked to offer examples as well as stories to allow a further exploration to emerge. It is worth noting that they were not asked initially to link their interpretation to nursing practice. It was felt that this could restrict the scope of data. Nevertheless, the discussion was then narrowed down to serve more specifically the study objectives (funnel structure).

The inductively produced themes show that the way surgical nurses understand health falls into three central categories. Then, these themes are deductively tested against the existing literature. This is consistent with the constructivist approach in this study which involves the use of induction (the discovery of constructs or patterns" and deduction (testing the overall constructs "in relation to the literature (Guba and Lincoln, 1994). Some of the categories involve sub-categories. These categories are presented in order of the frequency of occurrence in data.

1. Health as the absence of illness,
2. Health as being socially and psychological satisfied
3. Health as a clean environment.

Although the majority of these categories were generated as a response to questions about health, few were found in the context of answers related to other questions

(e.g. health promotion). Thus, for the sake of clarity and systematic analysis, themes and their categories were re-organized throughout the transcripts. .

6.2.1 Health as the Absence of Illness

In response to the question about nurses' understanding of health, adherence to the medical model view of health was dominant. Participants in both groups reported several links to this view. A cluster of elements found to support such a category include: "treating illness", "symptoms of illness", "diagnosing the illness" and "surgical interventions". The central category along with its elements is exemplified in the following extracts. Some extracts reflect the expressed agreement or otherwise among different participants. Indeed, as hand notes were made during discussions, non-verbal issues were integrated in the framework of analysis.

"...health is the absence of illness, you know we come across many patients on wards who suffer from health problems such as hypertension and diabetes"
(Surgical junior nurse1)

Another participant from the same group shows her agreement but with further comments

"I agree with this, we focus on medical problems and to be honest we rarely pay attention to other aspects of health" (Surgical junior nurse 3).

The researcher asked the participant to elaborate further on what she means by other aspects of care. The participant goes on to state :-

"That could include [other aspects of health] such as psychological and mental issues"

As such aspects of health were not automatically linked to their first reply to the question, it could be hypothesised that nurses might prioritise one aspect of health

over another and thus fragmentise the care. This is also reinforced in the following extract offered when participants were asked further about the aspect of care they most focus on.

“ I work [with orthopaedic patients], although patients need to feel comfortable; the thing I focus on most is the operation site, for example: infection and other symptoms such as dislocated bones” (Surgical junior nurse 4).

The above extract would suggest that whilst nurses might be aware of other aspects of health, in practice they focus on medical issues. Further, it is worth noting that the major aspect is the operation site, as opposed to the patient himself or family as well as the surrounding environment. These missing humanistic and holistic perspectives are of particular importance in the self-empowerment model of health promotion and working relationships between nurses which might lead to more effective health promotion work (Tones and Green, 2004). Similar emanating data from focus discussions with senior surgical nurses were consistent with this idea as illuminated by the following extracts:

“the aspect of health we focus on depends on where you work. I work mainly with pre- and post- op patients. I think that health means being aware of the medical complaint patients came with and the diagnosis”. (Senior surgical nurse2)

Another participant agreed with this and attempts to summarise the aspect of health they focus on by reporting that:

“Frankly, that is right we [surgical nurses], focus on medicine, illness and surgical interventions” (senior surgical nurse 4) (members of the group shook their heads as a sign of agreement).

On the basis of the above findings, it could be argued that surgical nurses' understanding of health is largely driven by the principles of the medical model (e.g. treating illness and its symptoms). Indeed, it should be noted that the focus of health is linked to the nature of the health problem itself rather than the expressed needs of

individuals. Whilst factors that could affect the development of nurses' roles in health promotion are reported elsewhere, evidence from the data indicates that lack of time could contribute to significant focus on the medical aspects of health. A number of participants (n=7) from both groups, suggested that the lack of time as well as the workload make it difficult to focus on different aspects of health. This is reflected below:

“In specialised units, we pay a lot of attention to other aspects [of health] such as mental and psychological. This is due to the small number of patients. The number of patients we look after on [surgical ward] is large and so we have no adequate time to focus on other aspects” (junior surgical nurse 3)

Another nurse also expressed her support and felt that:

“We usually have no time to offer psychological support to all patients: just some individual cases. You have many tasks to do in the surgical ward such as dressings” (junior surgical nurse 3).

At the time of data collection, it was noted that surgical nurses were often busy. This could contribute to nurses' medically oriented view of health. It seems also that health as a united concept is likely to be divided and its aspects prioritised. That is, psychological aspects of health are not given as much attention due to lack of time. It is surprising to note that psychological support is linked to the availability of time. Thus, it is not integrated into the overall framework of health. This finding echoes previous evidence suggesting that the lack of time is a barrier for having sufficient encounters with patients and thus explores their needs and promote health (McBride, 1994, Cross, 2005, Irvine, 2007). In this case, the fundamental aspects of the empowerment model of health promotion such as fostering self-esteem and self-efficacy are marginalised (Ewles and Simnett , 2004).

6.2.2 Health as being Socially and Psychologically Satisfied

Whilst viewing health from the medical perspective was given much attention by participants; some references were made to the social and psychological aspects of health. More attention to such aspects was offered by senior nurses in comparison to junior nurses. In addition to the possible difference in the theoretical input, this could be related to the length of experience and thus the frequent exposure to diverse cases. That is: the recognition of different aspects of health might be “picked up” by experience itself. The analysis reveals that being socially and psychologically satisfied are linked together. It was decided therefore to structure a category reflecting both of them. Although they are inter-related, emerging elements from the above category are limited. These include “spending a lot of time with patients to support them psychologically”, “encouraging lonely patients to talk to us [nurses]”, “answering their questions about their concerns”. This is further illuminated by the following discussion among participants:

“ I offer my patients’ psychological and social support as it is very important. Last week we had an 11 year old girl who had her right foot amputated due to an RTA. I spent plenty of time with her just to let her feel that she is not alone and to answer her questions” (senior surgical nurse 1)

“I think, that is right, she needs more than medicine [referring to the story of the little girl]. You know this is very important for speeding up her recovery”. (Senior surgical nurse 5)

“We know that doing these things is important but we do it for certain cases - if we have time” (senior surgical nurse 3)

Whilst it is acknowledged that support is needed for the reported case, three issues might be pointed out. Firstly, it should be noted that psychological and social support offered by nurses is indeed limited. For example, no mention was made to the role of the patient’s family in supporting their daughter with the help of other staff. It should

be noted that health is rooted in people's social norms (Tones and Green, 2004) and within the family context in Muslim countries (Gharaibeh et al, 2005). Whilst the questionnaire indicates that 59% (n=34) of nurses strongly support the item stating that the holistic understanding of health is important for effective care, the above findings suggest that health is viewed by nurses in a fragmented way. The mismatch might be explained by the possibility of agreeing with socially desirable answers. It should also be noted that focus group discussions generate more in-depth responses as opposed to the structured items in the questionnaire. Nevertheless, the limited view of health by nurses is confirmed by nurses' perception and practice of health promotion as explained in subsequent chapters.

Secondly, whilst multi-disciplinary work with other professions (e.g. psychologists and physiotherapists) is necessary for effective health promotion work (Seedhouse, 2004, Whitehead, 2004), such an element was also absent from nurses' understanding of health.

Thirdly, it is worth noting that social and psychological support is linked to the medical problem as well as the availability of time. This might indicate that "distressing cases" could stimulate nurses to pay attention to psychological and social health instead of offering it on a regular basis. However, some surgical patients might be distressed for reasons not related to the medical conditions and thus surgical nurses' ability to meet their need is questioned. Although evidence is limited, data from focus group discussions with junior nurses indicate that sometimes attention is given to individual cases.

"We focus on medical problems but sometimes we pay attention to other aspects of health as well as social issues" (junior surgical nurse 1).

Taking the above findings together, it can be argued that, when nurses attempt to adopt a more holistic frame of care, their understanding of other aspects of health revolves around the main health problem and is triggered by the confrontation of certain cases.

6.2.3 Health as a Good Environment

This category has emerged from focus group discussions with senior nurses. Acknowledging wider issues like the environment in the nurses' understanding of health is promising. However further analysis suggests that this broader dimension was expressed by only two participants (33%). In fact, it was reported during the discussion about health promotion. Indeed, elements that can be linked to the category are limited. This includes "safe environment" and "noise free wards". The following extracts offer the context of the category along with its elements.

"...health is not only about medical issues - ensuring a safe environment in the hospital is necessary. I would not allow cleaners to leave cleaning stuff in the corridors as this could harm people" (senior surgical nurse6)

Another participant further suggests that:

"Also you know creating a lot of noise is not healthy and could affect patients as well as staff" (senior surgical nurse 5).

The above extracts point out somewhat broader issues to health within the hospital setting. Whilst the importance of physical environment is acknowledged, social as well as organisational environment were missing (e.g friendly hospital atmosphere). On this basis, it seems that the focus of nurses has not moved beyond the area they work within. Importantly, the environment has not been linked clearly to other aspects of health, for example, could a relaxing environment enhance the psychological health of patients (Green et al, 2000). Thus, these findings do not sit systematically within the principles of a health promoting setting focusing on the creation of an environment conducive to health (WHO, 1997).

In summary, data from the questionnaire reveal the popularity of the medical view of health among surgical nurses and to a lesser extent medical nurses. The qualitative evidence from focus group discussions with surgical nurses displays three key images of health (see above). The prominent image is derived from the ideology of

the medical model of health concerned with its mechanistic functioning of the body. This is validated by the questionnaire results (see above) and previous work (McBride, 1994, Davies, 1995, Cross, 2005).

Whilst the medical framework of care needs not to be discredited in the surgical ward, it is not effective in addressing broader aspects of health (Tones, 2001). Other images have focused narrowly on psychological, social and environmental issues. When the latter images are to be valued, they are linked to the medical problem rather than to the context of the individual. Nevertheless, there is a lack of recognition of other images of health. For example, no reference was made to emotional and spiritual health. Yet, these aspects of health have a great importance for many people in many cultures (Lo et al, 2002) and thus should be taken into account by hospital nurses.

Likewise, positive images of health such as achieving individuals' aims and the adaptation to internal and external stimuli (e.g. lack of income) were missing. This is inconsistent with Dubos's (1965) theory of "adapting man" which advocates the stability and defined health as a state that enables the individual to adapt to the environment. Consequently, it could be argued that the holistic view of health, a cornerstone for health promotion, did not form surgical nurses' understanding of health. These findings form a platform for the next sections in this chapter.

6.3 Images of Health among Medical Nurses

In response to the question about the meaning of health three images were found. The representativeness of these images was examined in two ways: the occurrence of main statements in the transcript (e.g. social health) and elements found that can be addressed under a certain category (e.g. having good relationships with relatives and people). The images about health are discussed below.

6.3.1 Health as having a Good Social and Psychological Life

Unlike the focus group discussions with surgical nurses, it was surprising that participants automatically started talking about the importance of health from the social and psychological perspective. This evidence is confirmed by the questionnaire data indicating that medical nurses were not as supporting as their counterparts of the notion of health is the absence of illness. In fact, health is seen by medical nurses as good social and psychological life and not only the absence of disease. The analysis found that social and psychological life revolves around having good relations with relatives and friends as well as receiving good treatment. The above discussion is reflected in the following extracts:

“I think that health is not the absence of disease. It means feeling comfortable in life and having a good relationship with others such as friends and relatives” (medical junior nurse1)

“that is right, it means [health] having a good time with people you love” (medical junior nurse 2)

Another participant elaborates further and suggests once again that health is beyond the meaning of illness:

“ I have been working in nursing for 20 years. Health is not freedom from illness. Many patients feel unhappy because of other things such as being lonely. I think that health means maintaining good social relationships and being psychologically comfortable” (medical senior nurse 4).

Interestingly, another participant added a story based dimension to the psychological health. That is, effective communication skills.

“I think also psychological health needs good communication with patients. Unfortunately, this is something not given a lot of attention. Today the X- ray nurse

came to the ward to take a patient for an abdominal X- ray. She did not even smile when she met the patient. She was not friendly at all. The patient came back in tears because of the unfriendly approach. Not all nurses are like this but we often focus on medical problems rather than psychological issues (medical junior nurse 4).

“I do not think this is the case here [medical wards], offering patients with psychological support is an essential part of health which we focus on” (medical junior nurse 3).

In light of the above findings, it seems that nurses were cognisant with some complexity involved in viewing health. Indeed, acknowledging the lack of communication skills in relation to nurses’ understanding of health in its own right is encouraging. This resonates with the Ottawa Charter’s (WHO, 1986) actions for health promotion which emphasise the importance of developing personal communication skills with patients. Within the context of empowerment model for health promotion. This involves an active learning process and a two-way communication between health promoters and individuals ((McQueen, 2000, Canter, 2001).

In comparison with surgical nurses, medical nurses pay more attention to the social and psychological aspects of health. Nevertheless, it should be noted that social and psychological aspects of health were expressed within the context of the medical model as opposed to positive health as stressed by Chaves et al, (2005). For example, the concept “patients” was frequently cited with no clear referral to their families and their environment.

This could indicate that, whilst nurses might be aware of social and psychological aspects of health, the target is individuals with no attention placed on their context. This is an important point as in Jordan patients are often accompanied by extended family members who also need to be considered. On the basis of the above findings, it can be argued that, whilst medical nurses have discredited the exclusive medical

view of health, their understanding of other aspects of health were individualised and medically driven.

6.3.2 Health as being Financially Independent

Although data gathered to construct the above theme were produced only by two participants, it is worth exploration. The element found to be linked to being financially independent is the ability to work. This is mirrored in the following extracts.

“ I think also that health is the ability to work in order to be financially independent. You know living costs are expensive today and economic stability is important. For example, in this hospital some patients might be unable to pay the cost of their treatment and this could affect their health” (medical junior nurse1)

“Yes- health needs money!!” (medical Junior nurse 5)

Again, nurses demonstrated a further recognition of wider issues that could interplay with patients' health. It is worth noting that the ability to work was linked clearly to good economic status and thus health. This formula might be seen as a reflection on the current economic situation in Jordan following the recent Iraqi war.

At the time of data collection, many staff discussed the problems related to increasing prices (e.g. fuel, meat, vegetables and housing - due mainly to the increasing number of Iraqi refugees). Thus, there is a possibility that the consideration of wider issues of health might be triggered by the ongoing Iraqi conflict rather than by a theoretical background about the multi-dimensional nature of health. This theme is reinforced by data from the interview with the manager of training and development who pointed out that nurses in the hospital emigrate to other countries because of financial problems. This will be explored in Chapter 9.

6.3.3 Health as being Aware of Cultural and Religious Beliefs

The above image, which was missing in surgical nurses' interpretations of health, was given slight attention by two participants. It was associated with patients' needs as seen below:

“ I think that health could mean [understanding] people's cultural and religious beliefs. You know different patients have different needs and we learn from them about factors that could affect health” (medical junior nurse2)

“That is true, some patients here believe that life and death are controlled by the power of God” (medical junior nurse 4)

Whilst those who focused on this aspect of health are in the minority, it seems that nurses were cognisant of the potential impact of individuals' religious beliefs on their health. Exploring such beliefs is the benchmark for delivering congruent care as well as health promotion (Narayanasamy, 2001). More specifically the above responses meet the criteria of spiritual care identified by Van Leeuwen and Cusveller, (2004). These involve self-awareness and communication about cultural and religious beliefs of individuals. That is, it seems that a few participants were aware of the health care system as a cultural system (Kleinman, 1978 and Kim-Godwin et al, 2001).

However, *“learning from patients about health”* could raise two issues. Whilst this might be indicative of good communication and therefore assessment of patients' needs, it poses questions about nurses' theoretical input prior to getting in touch with them. The question is, therefore, if patients are unable to express their religious beliefs because of different problems (e.g. health status, uncomfortable environment), will nurses be able to intuitively consider them? This point needs further data especially from observations before being commented on.

Briefly, responses elicited from the question about nurses' understanding of health demonstrate some recognition of its diversity. Evidence from findings would suggest

that medical nurses are more cognisant of spiritual and economic aspects of health in comparison with their counterparts in surgical wards. However, responses from medical wards did not acknowledge other aspects of health. For example, it is not clear if emotional health can be related to social and psychological health. Likewise, the ability to work was seen purely as prerequisite to meet economic constraints rather than as a vehicle to achieve individual potential in a complex environment. However, health within the framework of actualisation incorporates not only achieving a high level of health during the entire life span but it also dynamically interacts with the constantly changing environment (Tones and Green (2004). That is, although surgical and medical wards had somewhat different views of health, its holistic nature was largely missing in all data from their discussions. This evidence needs to be taken into account when they express their understanding of health promotion and what they do in its name.

6.4 Images of Health among Patients

In response to the brainstorming question about the meaning of health, a wide range of interrelated responses was elicited. Some of the responses were offered automatically to other questions (e.g. the meaning of health promotion). Therefore, in order to identify and link themes together, each transcript was gone through as a whole, taking into account the study's questions. The subsequent items introduced by the researcher and triggered by the discussion allowed further exploration of existing images about the meaning of health among patients to emerge. Data were largely analysed using thematic analysis.

However, as part of the deductive analysis and in order to detect the occurrence of themes, a degree of quantification was also employed. The across-analysis shows 3 key images (themes) about health. Each image has a mixture of elements supporting its development and structure. The inductively derived analysis shows further that participants carry out certain activities to maintain good health.

Whilst health is a unified concept, its different aspects were divided in order to detect the level of understanding and the prevalence of a certain aspect (e.g. physical health). This also might enable the current researcher to identify those aspects of health that have been stressed or marginalised by nurses. In the light of growing debate about the meaning of health, it was decided to categorize and present images about health according to the level of complexity. If the image has only one aspect of health to focus on, the complexity level is 1. On the other hand, if the image involves two aspects of health, the level of complexity is 2. Finally, if it involves two or more aspects of health and linked to each other in one response; the complexity level would be 3. This quantification was used to examine the commonality of the theme rather than evaluating what image is better than others. Images of health and relevant clusters of meaning are given in table 4

Table (4): Central Images of Health and Relevant Clusters of Meaning

The image of health	Complexity level	Clusters of relevant meaning	Actions to maintain good health
Health is the freedom from illness	Level 1	1- having no diabetes and hypertension 2- the physical ability to work at home (e.g. housekeeping) 3- having physical health to achieve your future dreams. 4-not being obese 5- treating health problems as soon as possible	1- walking 2- taking herbs available in the kitchen 3- Eating good food (fresh and not frozen).
Health as having good social and psychological health.	Level two	1- being with your family 2- Having none of your family suffering from illness. 3- feeling happy and living without stress 4- being satisfied with yourself	1- Talking to your relatives and spending quality time together.
Health as being physically, psychologically, socially and economically satisfied.	Level three	1- Physical health, psychological health and having money are inseparable. 2- The ability to buy food that is good for your overall health. 3-the ability to buy medicine 4- The ability to pay the cost of your hospital treatment. 5- The ability to be admitted to private hospitals where the care is better.	1- Having a post and working hard to meet the economic demands. 2- The government needs to help poor patients to pay the cost of their treatment.

6.4.1 Health is the freedom from illness (Complexity Level 1)

The analysis of focus group discussions (n=4) found that being free from illness is a key image of health among participants. They felt that enjoying good physical health would ensure health gain and enable them to carry out daily activities. Elements of relevance to this image are “having no health problems”, “taking no medicine” and “not being obese”. In addition to the understanding of health elicited, data show that participants believe that certain activities are prerequisite for physical health and thus prevent the occurrence of illness (e.g. eating healthy food). As the responses were underpinned by one aspect of health, the construction of the image was simple and labelled as complexity level 1. The image and its elements are a feature of the following extracts:

“I think that health is having no health problems. I have 5 health problems, cardiac problem, asthma, hypertension, kidney problems. I am healthy when I can walk from the beginning of the corridor to its end”

(Medical male patient 1)

That is right; health means feeling well and you do not need to take medicine.

(Medical male patient 2)

Similar themes were found in the focus group discussion with female patients. Their responses were more concerned about the ability to work at home without experiencing the symptoms of illness.

“The first thing comes to my mind is the freedom from illness” (medical female patient 3)

“That is right” (medical female patient 4)

“Before I became ill, I used to be happy and work so hard at home. Now I feel all my life has changed. It is just suffering, I feel tired so quickly. (Medical female patient 5)

Another participant showed her agreement but offered further insights into the way in which physical health might affect individuals’ career future:

“... sometimes you have a lot of wishes but you cannot achieve them because of health problems. I am 19 years old and since I was 7 years I dreamt of being a hairdresser when I grew up. Unfortunately, I was diagnosed with lung problems and spent most of my life in hospitals” (medical female patient 6)

Other responses were accompanied by enhancing health actions and seeking health behaviour:

“I think that health is not having diabetes. I use herbs for my health problems but if they do not work, I go to my doctor” (surgical female patient 1)

Two participants in the same group pointed out further that in order to be physically healthy, you need fresh food. The second extract indicates interestingly the link between spiritual beliefs and health.

“good food makes you healthy, eating fresh vegetables and fruits is better than fatty food. You know sometimes you find the treatment in your kitchen! (Surgical female patient 5).

“health is not being obese, you know obesity causes heart problems....When I get unwell, I go to my doctor and stay at home and recite Quran and then I feel less stressed” (Surgical female patient 6)

Although the above responses are diverse and interconnected, they were underlined by the view of health as being the absence of illness. Evidence indicates that physical health is perceived as a tool enabling participants to carry out daily activities such as walking and working at home. Thus, health is more concerned with the physical function as opposed to positive which focuses on maximizing the potential of individuals and fostering personality growth (Katz et al, 2002, Chaves et al, 2005).

No evidence was found to suggest that the status of being free from illness might affect other aspects of health such as psychological and social life. Similarly, no

collected data would suggest that physical health could be shaped by environmental and political factors (Bowling, 2005). Whilst the view of health from the medical model is not wrong and is valid in its own right, its prevalence in the manuscripts could be associated with other issues.

As all participants had medical problems and were admitted for treatment, it might be possible that their first concern was to gain physical health and go home. The focus on the medical view of health may also be associated with the environment itself. During the hospitalization time, many patients are often exposed to medical treatment, investigations and health stories from other patients. On this basis, it can be suggested that participant's medical understanding of health might be influenced by the hospital environment as well as situational factors. This is illuminated by linking the experienced health problem to the way in which health is perceived. For example, it was found that diabetic patients perceive health as having no diabetes. The question about the meaning of health however was asked in a way that did not confine the possible wide range of responses.

That is, it was not linked and directed to a specific environment or medical problem. Interestingly, these findings are congruent with the majority of nurses' interpretations of health. There is a possibility therefore that patients' medical understanding of health was influenced by the philosophy and experience of care in operation. A philosophy that was traditionally derived from the principles of the medical model of health concerned more about the mechanistic functioning of individuals as opposed to the consideration of socioeconomic status and the holism of health. The extracts such as "*not taking medicine*" and "*walking in the corridor*" might be a reflection of what nurses focus on at the time of interaction with patients. This substantiated the observational evidence about the nature and the content of interaction between nurses and patients, which was, an interaction largely shaped by nurses' agenda and exemplified by an information giving approach (Furber, 2000, Irvine, 2007). This is to be fully examined in chapter 8.

Interesting findings to note are the activities carried out by participants to enhance physical health and avoid illness. Walking, eating good food and using herbs were expressed recurrently by the participants, particularly women. These elements might suggest that patients have developed their own expertise in health care because of the episodes of illness and learning from other people's experiences of health and illness. Indeed, it seems that they established their "action map" to deal with illness. For example, using herbs as a first action and then if that does not work, visiting the doctor is the next action. Such evidence is in accordance with the Mexican studies indicating that female patients develop their own health strategies to deal with illness as a result of previous episodes of illness and learning from the older generation within the family context (Maddox, 1999, Yoho, and Ezeobele, 2002). This is an important issue as patients in this study perceive health promotion as having adequate health knowledge which enable particularly female patients to act as health carers for the family. This is to be explored in section 7.5.1.

On the basis of above analysis, it can be argued that hospital nurses need to explore patients' own health and care expertise and collaboratively examine with them how it might fit in with the nursing care plan. This might maximise patients' receptivity to nurses' role in health promotion (Higgins and Learn, 1999, Mclennan and Khavarpour 2004).

In addition to above , it should be noted that reciting Quran as a religious and spiritual practice was only reported by a female participant. The examination of her background found that she had been suffering from health problems since childhood with no significant medical progress to date. As a result she felt that focusing on religious beliefs could be the best way of healing. That is, it seems that religious practices are considered when medical treatment is no longer effective. This evidence is confirmed by previous work suggesting that many Jordanians believe that illness and wellness is God's will (Haddad et al, 2004, Gharaibeh et al, 2005).

Yet, in light of the above evidence, spirituality was reported not only as a treatment intervention but also as a way of enhancing various aspects of health (e.g.

psychological health that could reduce stress)". This aspect of health was largely marginalised by nurses, particularly those who work in surgical wards.

Likewise, it should be noted that physical ability was associated with two physical locations. Generally the "home" and specifically the "kitchen". Given that only female participants generated these links, they might be indicative of their gendered roles in the family as homemakers focusing on household issues. In other words, as validated by a previous Jordanian study (Mahasneh, 2001), feeling physically unwell might comprise the fulfilment of such roles and thus affect the overall health of the family.

6.4.2 Health as having Good Social and Psychological Health (Complexity Level 2)

The analysis reveals more complex development of the interpretations of health reported by the participants. In line with previous studies (Yoho and Ezeobele, 2002, Hjelm et al, 2005), viewing health from both social and psychological perspectives as an interpretation was felt by almost half of participants (n=11, 47%). Given that these twin aspects of health were expressed together, they were not separated in the analysis process. The integrity and the complexity of responses therefore were secured. Being with other family members and living without stress is the feature of this image. The notion that medical health alone is not enough is also a key principle of this image. Together, this image, and its elements are encapsulated in the following extracts:

"I think that health is not only good physical health, it is also concerned about psychological health. I think that many problems are related to the social and psychological problems" (Surgical male patient 1)

"..... plenty of problems are caused by psychological reasons. If you are relaxed and happy from inside your overall health will be good (surgical male patient 2)

“That is right,...You could even have cancer but if you have good socio-psychological support and you are determined to live your life you would look like someone suffering from no medical problem (surgical male patient 3).

“ Health means being among your family members. If one of your family suffers, all members of the family suffer as well”(Surgical male patient 5)

Female patients also felt that psychological health is important for achieving your goals:

“I think that psychological status is important. When you feel happy and have no stress, you study and work better” (medical female patient 2).

However, within the context of psychological health, a participant criticised nurses and stated that:

“ as a patient, I think that nurses need to focus on psychological aspects. They care only about treatment and injections!” (surgical male patient 6)

Whilst it seems that participants were cognizant of the importance of both social and psychological health; these aspects were only linked to physical health. That is, good social and psychological life might prevent medical problems. For instance, psychological health was not seen as a tool to allow individuals to release their potential and thus foster self-confidence and life skills.

Given the strong ties among family members in Jordan and the popularity of the extended family system, findings indicate that focusing only on medical issues might not be congruent with the patients' needs. Although the concept of “adaptation” was not specifically mentioned, its relevant components were sketched. It was pointed out that determination is needed to adjust to the possible internal and external stressors and work towards the achievement of life goals.

However, social and psychological aspects of health were not interrelated to other aspects of health such as environmental. Thus, adaptation to the changing environment, as argued by Dubos's (1965) theory (adapting man), might not occur. Keeping this in mind, nurses need to identify the stressors that could prevent patients from a full adaptation to a stressful situation. This is to be explored further in light of the congruence or otherwise between nurses' role in health promotion and patients' needs.

Finally, it is worth noting that within the context of psychological and social health, no reference was made to sexual health. It was felt that the discussions were largely occupied by talking about physical health as well as economic stability (see below). These aspects might be prioritised over other aspects at the time of data collection. However, this might not be an indication of marginalization of these aspects of health but rather, a reflection of both cultural and methodological issues. For instance; talking publicly about sexual health is still a taboo in Jordan. Methodologically, it is possible that patients felt uncomfortable to discuss such an aspect of health due to the fear of exposing their personal issues in the group.

6.4.3 Health as being Physically, Psychologically, Socially and Economically Satisfied: (Complexity Level 3)

The across analysis of focus group discussions (n=4) reveals that out of all participants (n=23), six of them (26%) perceived health in a more systematic and complex way. Whilst they are a minority, participants offered evidence about how the holistic meaning of health can be contextually constructed. In addition to the recognition of images outlined above, it was found that good economic status is a contributing factor which might shape other aspects of health (e.g. physical and psychological). That is, the image has diverse but interrelated components. Accordingly, it was credited a complexity level of three. The complexity of this image is in line with the ideology of health promotion operating at a wider level such as economic status of individuals and the holism of health (Tones and Green, 2004). It is interesting therefore to detect a more sophisticated understanding of health that

is economically constructed. Being able to work and having a post were seen as a prerequisite for good economic stability and enjoying other aspects of health such as the physical and psychological. The illumination of this economic image of health is given and its links verified by the following extracts:

“ it is not only about physical and psychological health. Health is being independent economically and having a post. I wish I could go back to my work and support my self and my family” (medical male patient 4)

A university student also expressed his frustration and anxiety due to the lack of money. According to him, this affected his recovery and psychological status.

“..I feel so sad when I see my dad work so hard to offer me the cost of treatment.. if my economic status was good, I would not worry about this and psychologically I would feel satisfied and sleep well!!” (Medical male patient 5)

“That is right, health means to have money so you do not start begging to cover the cost of your expenses! This alone makes you socially isolated and psychologically worried. (Medical male patient 3).

Surgical patients were also concerned about the impact of unstable family economy on their health.

“I think that the current people’s health is likely to be bad psychologically. You know living costs have increased dramatically. The lack of money makes your psychological health bad and thus the overall health”(surgical male patient 4)

“.....no doubt I also believe that having adequate money could be seen as an important factor to having good health. For example, buying good quality food and medicine needs money! (Surgical male patient 6)

As highlighted above, participants felt that being able to meet the economic demands of the whole family is an essential element of good health. Whilst other aspects of

health were acknowledged, it seems that being economically satisfied is at the heart of their responses.

These findings are indicative of recognition of the overlapping issues related to health. Some phrases used by participants such as “socially isolated” and “psychologically worried” shed light on the impact of the economic burden on self growth. These elements are against the thesis of self-empowerment ideology and thus health promotion (Mok and Au-Yeung, 2001, Houston and Cowley, 2002). Indeed, it contradicts Orem’s (1995) self-care theory of nursing suggesting that health is a state characterised by contentment towards fulfilment of one’s self ideal. Likewise, the Maslow’s self actualisation model (1976) highlights the fact there is no self-actualisation if the basic needs are not met (e.g. treatment). That is, in the current analysis, patients might not be able to reach the state of actualisation unless they are financially well supported (Raphael, 2001).

In addition to the lack of support at a national level (e.g. free treatment), the extended family as a support and burden system might add further economic constraints on the shoulder of patients. The net result of these factors could have a negative impact on other aspects of health especially psychological health. That is, it seems that there are broader issues interplaying with patients’ health at both individual and national levels.

Such evidence raises concerns about the extent to which nurses are sensitive and aware of the complexity of structural determinants of health. However, nurses’ perceptions of health did not largely encapsulate such issues. This raises concerns about their role in promoting the health of patients. The picture about health as actualisation is incomplete unless its fundamental principles are acknowledged (Pender, 1996).

The across analysis of focus group discussions indicates that, whilst female patients view health from medical, social and psychological perspectives, no referral was made to economic issues. The reason might lie in the role of men and women in the

Jordanian society. Whilst many of Jordanian women work in different fields, their role as housewives is still popular. This is verified by the referral made to the “home” and “kitchen”. In contrast, men (single and married) are required to be capable of meeting the economic needs of the family and thus having a post is essential.

It is worth noting that the average age of male participants in both group discussions is 37 and 45 years. This might be associated with having more economic problems due to increasing demands such as raising children and offering them the education needed. That is, men in this study might have felt more concerned about economic issues given their role as breadwinners in the Jordanian society.

In summary, the analysis shows three images of health among participants with different levels of complexity ranging from 1-3. That is: medical, psychological and social and economical. Spirituality, together with other physical activities, was seen to enhance health. Whilst these images are diverse, they are largely underlined by an orientation towards the freedom of illness status as opposed to positive health focusing on self-actualization and fostering resilience which in turn might enhance prospects for effective living (.Chaves et al, 2005). A limited number of male participants show that economic stability might shape all other aspects of health and thus the extent to which health can be gained. However, patients’ understanding of health might be triggered by situational factors such as being already ill at the hospital and unable to pay the cost of the treatment. The extent to which patients’ understanding of health might affect the way in which health promotion is perceived is the focus of the next chapter.

6.5 Summary of Hospital Nurses' and patients' Understanding of Health

This chapter reports findings related to the way health is understood by hospital nurses and patients. The overall data indicate that nurses' understanding of health is fragmented. It appears that health is biased towards one or two facets of health as opposed to a holistic view capturing a fuller picture of health. Elements related to the positive meaning of health such as personality growth and building strength were largely absent in nurses' perceptions. That is, it seems that unless nurses are cognisant of the complexity of health as a concept, their capability to deliver holistic care and plausibly health promotion activities could be questioned.

The theoretical grounding of this thesis suggests that the congruence between nurses' beliefs and understanding of health and patients' own conceptualisations might be a prerequisite for delivering culturally competent care and health promotion (Yoho and Ezeobele, 2002, McLennan, and Khavarpour, 2004). This chapter however shows a different reality. Whilst nurses and patients viewed health from the medical perspective, nurses did not devote much attention to economic and spiritual factors in contrast to the patients. The latter aspect of health has been seen as a key criterion to evaluate the robustness of health models (Lo et al, 2002, Chaves et al, 2005).

In the light of above, there is some dichotomy between nurses' understanding of health and patients' own conceptualisations. This discrepancy might not be explained purely by the lack of nurses' knowledge of patients' priorities but also by situational factors. At the time of data collection, some of those patients who participated in the focus group discussions had problems in paying their health insurance. Further, many of those patients came from a poor background (e.g. Baqa refugees' camp). Their economic perceptions of health might be influenced or determined by such issues.

However, regardless of what could constitute such perceptions, the mismatch between nurses' and patients' conceptualisations of health could create difficulties in delivering health promotion targeting patients' own identified needs (Tones and Green 2004, McLennan, and Khavarpour, 2004). As caregivers and caretakers had different perceptions of health in mind, one might wonder how two-way

communication and negotiation principles can be utilised. That is, the discrepancy outlined above could restrict the establishment of more effective health promotion interventions operated at the individualised level.

Previous studies in health and health promotion have been criticised on the grounds of the exclusive focus on one gender (Dickinson and Bhatt 1994, Paxston et al, Maddox, 1999, Yoho and Ezeobele, 2002, Hjelm et al, 2005). Whilst similarities in perceptions of health are acknowledged among men and women (e.g. health as the absence of illness), there are some gender associated differences and thus potential implications for practice. Men in this study were more concerned about financial status than women. Although some evidence suggests that women were concerned about eating healthy food, no explicit references were made to the financial burdens and health. By contrast, the perception of health among men revolved around having a post and adequate money in order to fulfil the financial commitments of their families.

On this basis, male patients might have much more complex needs while in hospital. Nevertheless, findings from the focus group discussions show that nurses were not sensitive to potential gender differences in respect of the way in which health is perceived. Consequently, there is a danger of utilising a standardised caring approach conflicting with gender issues and therefore health promotion needs during hospitalisation. In a recent quantitative Jordanian study, it was found that the majority of female patients prefer to be looked after by female nurses (Ahmad and Alasad 2007). The chapter however reveals that the issue is not only about gender preferences but also about the differences in perceptions and thus expectations (See the above). Such differences are of importance to the development of delivering health promotion activities sensitive to cultural and gender issues.

Chapter Seven: Hospital Nurses' Role in Health Promotion

7.1 Introduction

This chapter presents findings concerning hospital nurses' attitudes towards their role in health promotion in general. Their understanding of health promotion together with

related experiences are highlighted. In order to offer a deductive picture about their role in health promotion, data from the questionnaire are given first. Then, a more in depth picture about such a role is seen in light of evidence generated from the focus group discussions. Following this, patients' understanding of health promotion as well as related experiences is highlighted. The nature of hospital nurses' role in health promotion from the perspective of ward supervisors, the nursing educator and the manager of training and development is examined.

7.2 Views towards Hospital Nurses' Role in Health Promotion

A set of items (n=6) was used to examine the overall views towards nurses' roles in health promotion as well as other issues of relevance. The items, along with their findings, are presented in Table (5). Just about half of respondents (49%, n=26) agree strongly with the item stressing the importance of their role in health promotion. When they were asked to offer their views about the suitability of a hospital as health promoting setting, two-thirds of respondents (60%, n=35) agreed with the item.

It was also found that nearly two-thirds of respondents (60%, n=32) disagree with the item stating that "health promotion is a waste of time". The average score of 3.8 suggests that respondents generally disagree with the negative item. Thus, it seems that respondents generally felt positive regarding their role in health promotion as well as the need for hospitals to pay attention to promoting patients' health. In line with the issue "victim blaming", respondents were asked to offer their views about whether those responsible for damaging their health should not receive any health promotion. It was found that about two-thirds of respondents (62%, n=36) disagree or strongly disagree with such an idea. The average score of this negative item is 3.4. Generally speaking, it would seem that the majority of respondents disagree with the

item. Finally, respondents' views towards the importance of therapeutic communication between nurses and patients to deliver effective health promotion activities were examined. Slightly above half of respondents (52%,n=30, mean score=4.3) expressed their strong agreement. No statistically significant findings were detected between the reported items and demographic data.

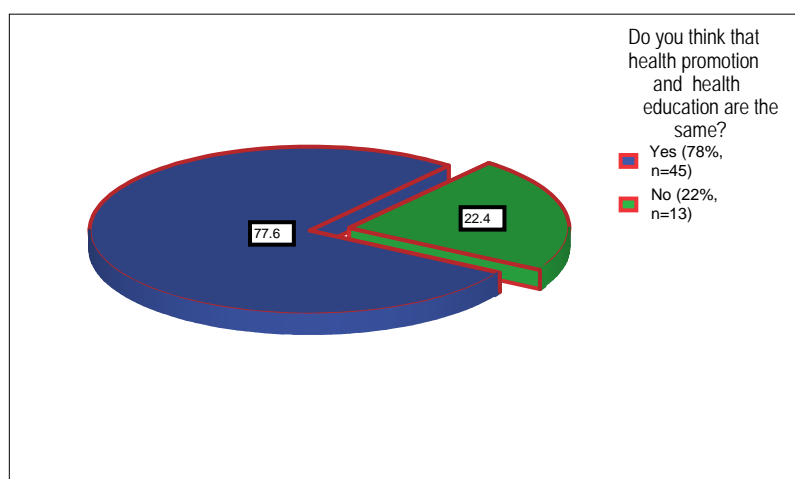
Table (5): Respondents' Views towards their Role in Health Promotion

Items	Strongly Agree	Agree	Cannot decide	Disagree	Strongly Disagree	Total	The mean scores
1- Hospital nurses have an important role in promoting patients' health	53%,n=31	43%,n=25	3%,n=2	-----	-----	58	4.5
2- Hospitals are a suitable place to promote patients' health	31%,n=18	60%,n=35	2%,n=1	2%,n=1	5%,n=3	58	4.1
3- The hospital needs to take more responsibility for promoting patients' health	59%,n=34	40%,n=23	3%,n=2	2%,n=1	-----	58	4.6
4- Health promotion is a waste of time *Negative item 1-5	3%,n=2	17%,n=10	60%,n=35	19%,n=11	58	3.9
5- Patients responsible for damaging their health should not receive any health promotion. *Negative item 1-5	19%,n=11	14%,n=8	5%,n=3	35%,n=20	28%,n=16	58	3.4
6- Therapeutic communication between nurses and patients could have a strong impact on the achievement of health promotion.	52%,n=30	35%,n=20	7%,n=4	7%,n=4	-----	58	4.3

An open ended question was used to elicit respondents' ability to distinguish between health promotion and health education. Data were sought on this topic by initially asking respondents if health promotion and health education are the same. Then, if the answer was no, they were further asked to describe their meanings. Given the nature of qualitative data they have offered, grouping and coding

procedures were used. Initially, all qualitative data were scanned to identify the commonality of certain themes. Then, each theme was coded and entered into SPSS for further analysis. For example, number 1 was allocated to the theme “maintaining good health” and then listed under a variable - either health promotion or health education. To keep the depth feature of qualitative data, the context of themes is also given. Pie chart (2) reveals that only a small proportion of respondents (22%, n=13) believed that health promotion and health education are not the same. Two of these respondents did not offer any descriptions of their meanings. No significant findings were found in relation to the demographic data.

Pie chart (2): Respondents' views towards the difference between health promotion and health education



Of all who claimed that health promotion and health education are not the same (n=11), (85%) failed to offer a clear and comprehensive picture about their meanings. That is, whilst intuitively they could recognise that health promotion and health education are not the same, their descriptions raise questions about their actual ability to distinguish between them. Whilst “giving knowledge about health” was the most frequently cited vague description of health promotion, “educating patients about their medicine” was a key element of their understanding of health education. Although the number of respondents is too small (n=11) to generalise findings, the above findings are indicative. They need to be considered throughout data analysis of qualitative materials. Adhering to the medical model is evident. The following extracts offer further knowledge about the context of the identified themes.

“health promotion is how to keep your health in good condition, you need to look after yourself” (respondent 13)

“Health education is like giving information about the side effects of medicine and its indications” (respondent 45)

“Health education is giving advice about what a certain medicine is for and how you need to take it at home” (respondent 33)

The above descriptions are indeed narrow as opposed to the complexity and comprehensiveness of health promotion. For instance, empowering patients, fostering self-esteem, negotiating care and integrating a health policy into care were absent (Tones and Green, 2004, Whitehead, 2005). As the questionnaire examined respondents' views towards health itself, such findings are not unexpected. In fact, the vast majority of respondents believe that health is freedom from illness. This could explain the poorly developed understanding of both health promotion and health education. However, the above evidence is informed by limited qualitative data. Thus, there is a need for complementary findings from focus group discussions to strengthen or otherwise its ground.

7.3 Images of Understanding Health Promotion among Surgical Nurses

The question and consequent items introduced by the researcher about nurses' understanding of health promotion generated wide but inter-related responses. Almost all participants used the concepts “health promotion” and “health education” interchangeably during the discussions. Thus, it was felt that participants were confused about certain concepts before they were asked to distinguish between them. This is largely consistent with the findings from the questionnaire (see above) and previous studies (Cross, 2007, Casey, 2007). Questions were mainly asked about how they understand health promotion and health education without initially linking them to their role as nurses. This is in order allow a fuller picture to emerge. They were asked to comment on any potential difference between concepts. The deductive

as well as inductive scanning of data suggests that data did not relate specifically to specific question. It was decided therefore to thematically analyse the total transcripts and apply a categorisation system into the content of data. More specifically, the analysis was guided by the formula:

1. Health promotion= health education+ health policy
and
2. The framework of health promoting hospitals offered by WHO (1997).

The aim of health promotion work, its components, the target and the methods of delivery were analysed and used to structure the overall category covering such issues. Accordingly, two main categories were structured as outlined below:

- (1) Micro-role of health promotion
- (2) Macro-role of health promotion

Although the above categories are interconnected, they are discussed separately for the sake of clarity. As there are some differences among surgical and medical nurses concerning how health is viewed, the above categories will be applied according to the area of practice (surgical and medical wards). This might enable similarities and differences in terms of how nurses' roles in health promotion are developed to be examined. Each category and possible underlying themes are accompanied by excerpts from data to maximise their credibility.

7.3.1 Micro-role of Health Promotion

The analysis shows that the micro-role of health promotion had a small area to focus on. This mainly includes patients and their health problems and general issues with the ward boarders. Preventing disease and complications and helping patients to adapt to health problems are not only the features of this category but at also the aim of (perceived) health promotion work. The following extracts encapsulate these ideas:

“ I think that health promotion means to me how to achieve the aim of my care and reduce the possibility of complications such as infection” (senior surgical nurse 1).

Another participant showed her agreement and went further to suggest that :

“ I would like also to say that disease prevention is more important than health promotion. They are not the same. For example, disease prevention is helping patients not to smoke in order to prevent illness whereas health promotion is to avoid complications such as respiratory problems” (senior surgical nurse2).

The thematic analysis also reveals that junior nurses’ understanding of health promotion is closely related to the above extracts.

“I think that health promotion and health education are the same. It means helping people to adapt with their illness through educating them” (junior surgical nurse3)

“That is right. We offer them some advice about what to do and what not do. Every one has a role to play to teach patients about how to take insulin. On the other hand, nutritionist offer the diabetic patient the related health education about diet” (junior surgical nurse 2)

Another participant elaborates more about the meaning of health promotion and adds further confirmation regarding the lack of understanding, its meaning and ideology as stated below:-

“we do it automatically but we do not recognise if it is health promotion! Eventually, assessing patients and offering help could be seen as health promotion” (senior surgical nurse3)

The above extracts suggest that nurses are lacking a more holistic understanding of health promotion and its components such as health education. There is no attention given to the positive meaning of health such as helping patients to achieve their own

goals which are not linked to illness (Bowling, 2005). Nurses' understanding of health is more concerned about tertiary prevention as opposed to primary and secondary.

Whilst educating patients might promote health, it would appear that related activities are carried out through utilising a hierarchy expert-led approach as opposed to the negotiated and therapeutic relationship approach suggested by health promotion scholars (Seedhouse 2004, Tones and Green, 2004).

That is, nurses know best for patients and the expectation is that patients will comply with their advice. This is further illustrated by the underlined extracts. Although the aim is illumination rather generalisation, light needs to be shed on two issues.

Firstly, it would appear that nurses had a strong belief that health advice would result in promoting health. Such a belief supports the rational empirical theory that assumes that clients will make rational decisions based on view of information given to them (Baird, 1998). This assumption is, in its own right, faulty in light of health promotion models and theories. As explored in chapter 3, social learning theory might explain health behaviours and its underlying cognitive process (MacDonald, 2000). However, socio-cognitive theories are based on a preventive health framework and thus sit more comfortably with traditionally defined health education as opposed to a wider reaching health promotion ideology operating at social, empowerment and economic levels (Clark, 1998, Cullen, 2002).

Indeed, not only are economic and political dimensions missing at the level which health promotion operates but also findings suggest that information-giving is lacking key principles. For example, collaboration and participation were not associated with patients' education. Analysis indicates that inter-sectional and multi-disciplinary work, lobbying and advocacy were absent from nurses' interpretations of health promotion and activities. In fact, perceptions are against these principles. For instance, it seems that care is carried out in a fragmented way, lacking collaboration amongst professionals. As outlined in the above extracts, the nurse and nutritionists

offer care separately in terms of educating patients. On this basis, it could be argued that nurses operate within the ideology of health education as opposed to encapsulating health promotion (e.g. empowerment and health policy). The theoretical background of this thesis argues that health education alone is ineffective, ethically questioned and fails to address wider issues pertinent to health (Piper and Brown, 1998, Tones, 2001, Casey, 2007). The reality is that the aim of health promotion is widely political (Seedhouse, 2004). Therefore, it seems that hospital nurses in this study need to understand broader meanings of health promotion in order to achieve a high quality of holistic care.

Secondly, as nurses' understanding of health promotion and experiences are informed by an expert-led approach, ethical dilemmas could emerge. This includes "victim blaming" as well as interfering with patients' rights to choose their own lifestyle even if it is damaging. In other words, their autonomy could be threatened due to the lack of partnership communication approach used by nurses and informed by possible imbalance in power principles as shown in the following chapters of this thesis.

In brief, like previous studies (McBride, 1995, Cross, 2005, Casey, 2007), the majority of participants in surgical wards hold a micro-role of health promotion which is lacking a firm theoretical background and rooted in a simplistic health education ideology and related socio-cognitive theories. Such a role tends to focus on delivering individual-to-individual health education activities that could prevent disease and complications. Not only is the micro-role of health promotions informed by the medical model but it also does not acknowledge the complexity of health promotion work. This is evident from the absence of key principles such as empowering individuals and considering their socio-economic status. On this basis, the effectiveness of the above role is debated as being ethically unsound.

7.3.2 Macro-role of Health Promotion

In the second category, whilst the number is limited (n=4), some participants moved beyond the micro-role of health promotion. That is, a more comprehensive and complex picture of health promotion has emerged. This category could indicate a more advanced understanding of health promotion and, presumably, practice in comparison with the earlier one. However, it should be pointed out that the “macro-role” might not be perfect in the light of the recent development of health promotion literature. The reinforcing elements found in the analysis associated with the above category are discussed below.

In addition to the recognition of health advice as part of health education, the concept of empowerment was found in few interpretations of health promotion. One of the participants made her contribution in the discussion and asserts that:

“I think that health education is part of health promotion such as providing patients with the knowledge needed to take into account the nature of their illness. In contrast, health promotion means empowering patients to prevent illness and to adapt to illness for the rest of their life” (junior surgical nurse3).

Although it seems that empowerment has an illness oriented focus, it would appear that the complexity of health promotion to some extent was acknowledged. Health education was seen as a part of health promotion and empowerment as a broader issue linked to health promotion. On this basis, the role of hospital nurses in health promotion therefore is to foster the beliefs in self-efficacy that might lead to making an informed decision (Ewles and Simnett, 2004)

However, it is worth noting that empowerment was not perceived as a legitimate subject matter of health promotion in its own right (Tones and Green, 2004). Rather, its main aim is to focus on illness related themes. That is, the broader understanding of health promotion has been confined by associating it with illness as opposed to empowering the wellbeing of people. This is because the capacity to make decisions

is influenced by the self-esteem (Randle, 2003). Enhancing self-esteem (high ranking of self-value) is an important element of the self-empowering approach to health promotion (Berndt and Burgy, 1996).

Another participant outlined an important ethical issue based on her experience:

“according to my experience, health promotion means respecting patients’ personal decisions despite the fact that such decisions could conflict with their health improvement. I came cross a patient suffering from lung cancer. He was a very heavy smoker. I talked with him about the danger of continuous smoking but he did not pay any attention. In this case, I believe that his decision should be respected. (Junior senior nurse 4)

As outlined, it would appear that a key element of health promotion was considered i.e. respecting the individual’s decision which could foster trust in relationships between patients and nurses. This is despite the fact that it might conflict with staff opinions and prescribed treatment. However, whilst a fuller understanding of health promotion is acknowledged, the extract adds further illumination about the nature of overall health promotion work. Health advice, lifestyle and an individual-to-individual approach are favoured by nurses. For example, no referral was made to socio-economic and structural issues which might interplay with the individual’s lifestyle (e.g. stress, unemployment, education).

Moreover, the analysis reveals that the minority of participants (n=2) attempt to consider wider issues of health promotion. This includes health policy and an environment free of pollution. These responses are consistent with the Ottawa Charter Declaration (1986) and Vienna recommendations for health promoting hospitals (WHO, 1997) which point out the importance of healthy policy formulation and an environment conducive to health. These responses are the features of the following extracts:

“...health promotion means effective health policy. A long time ago patients and sometimes medical staff used to smoke on the balconies - they were horrible areas! Recently the hospital launched a new policy preventing people smoking in the hospital. Now smokers have their own smoking zones. I know some people might not comply with the policy but we have seen some progress” (Senior surgical nurse 4)

“I think that when we talk about health promotion, we need to focus on the environment. Here the air is so polluted because the [cars emission]. Health promotion is the good environment” (senior surgical nurse2)

It seems that the minority of nurses are cognisant with some broader issues of health promotion and where its effectiveness might lie. Further, in line with the concept of a health promoting hospital, the extract sheds light on the hospital's intention to play a key role in promoting health through establishing health policies. Further, some recognition of the importance of the environment for promoting health was expressed. However, other principles inherent in more recent paradigms of health promotion were absent. This includes, equity, participation, inter-sectoral and multi-disciplinary collaboration and creating channels with the local community and other health organisations (Whitehead, 2005, Groene and Garcia-Barbero, 2005). Therefore, whilst the macro-role of health promotion appears to be more advanced than the micro-role in the current data, the full acknowledgment of both the complexity and comprehensiveness of health promotion was not found.

In addition, the identified factors might affect the development of nurses' health promotion roles (see below), two issues worth elaboration in the current section. The lack of clarity of health promotion and its components could be linked to the limited understanding of health itself as commented on earlier. Further, when nurses seem to have a good grasp of health promotional knowledge, it is often associated with illness as opposed to positive and holistic health. This could be explained by the nature of wards already focusing on people with health problems. Whilst the issue is acknowledged, the comprehensiveness of health promotion should not be restricted by situational factors. As pointed out earlier, questions were asked initially in a way

that confined nurses' responses to a specific role. On this basis, it could be argued that, whilst a few nurses had some recognition of the complexity of health promotion, an exclusive focus on medical ideology was underlying all themes. It can be concluded that whilst the nurses' perceived role in health is limited, there are individualised differences amongst them which need to be considered. Such a difference might be better dealt with not only by effective nursing health promotion curricula but also by ensuring the availability of role models of nurse health promoters in clinical practice. This is an important issue as Chapter 3 argues that within the clinical learning environment there is a shortage of new role models in health promotion (Smith et al, 1995b, Schickler et al 2002) and thus a limited integration of theory and practice of its principles.

7.4 Images of Understanding Health Promotion among Medical Nurses

Responses offered by participants to the question about their understanding of health promotion were diverse and inter-related. For example, some responses contain different themes at the same time: the meaning of health promotion, its aim, the content and the target. It was decided therefore to use the same categories used with surgical nurses. This is not only to allow comparisons to be detected but also to prevent simplifying the complexity of responses.

7.4.1 Micro-role of Health Promotion

Under this category, analysis revealed that health promotion is perceived as health education and vice versa. The aim was to correct behaviour and to educate patients about following a healthy lifestyle. Whilst the described activities are different, they can be addressed under health education rather than health promotion. The target is often an individual and a one-to-one expert-led approach is often in operation. The recognition of wider issues involved in health promotion work (e.g. empowerment and socioeconomic factors) is either absent or unclear. Further illumination on these features is inherent in the following extracts:

“ I think that health promotion and health education are the same. They mean promoting patients’ health. For example, diabetic patients need to be informed about how to change their lifestyle such as not eating a lot of sugary stuff” (medical senior nurse 1)

Likewise, another participant goes on to suggest that:

“Health promotion means not to follow bad lifestyle habits such as smoking. We point out the risk of smoking in order to ensure that patients would give up.(medical junior nurse 1)

“I agree with my colleague, it [health promotion] means health knowledge and treatment. For example, teaching patients about how to take insulin is likely to promote their health and they would be happy to do something by themselves” (medical junior nurse 3).

In an endeavour to show some difference between concepts, another participant stated

“ I think that health promotion and health education are not 100% the same. Health promotion is a bigger word than health education. It means planning and implementing a full program. In contrast, health education could mean correcting patients’ health knowledge”. .(medical junior nurse 4).

As the case with emanating findings from discussions with surgical nurses, health promotion is seen as a tool to promote patients’ health by preventing illness and future complications. On this basis, the focus is on tertiary prevention as opposed to primary and secondary.

An interesting finding to note is the tendency to correct patients’ behaviour by offering them health knowledge. This is a simplistic view of health education and it does not sit well with the ideology of health promotion. As this approach lacks

empowerment and the active involvement of patients, its effectiveness is questioned (Casey, 2007, Kelly and Abraham, 2007).

This is further reinforced by the marginalisation of other factors that can interplay with people's lifestyle (e.g. lack of education and social support and poverty). However, the above findings are largely guided by socio-cognitive theories that might explain the link between health knowledge and behaviour but they do not offer solutions by themselves (MacDonald, 2000). There is therefore a danger from linking the medical knowledge of health with the possibility of enhancing people's overall health status (Whithead, 2002, Ewles and Simmnett, 2003).

Although participants discredited the medical model view of health as discussed earlier, its ideology underlines what they carry out in the name of health promotion. Health knowledge was linked to ill people rather than to a wider group of the community. Whilst it is recognised that teaching health knowledge might empower patients, it would appear that the concept of empowerment itself did not form the grounds of their activities. It should be noted that empowering people through information-giving depends on how this is communicated and approached. It is argued that working relationships between nurses and patients can affect the effectiveness of health promotion strategies and particularly the utilization of the empowerment model (Tones, 2001, Webster and French, 2002).

Evidence from the above findings however indicates that the approach in operation is presumably a one-to-one expert-led basis as opposed to two-way communication and collaboration. For example, information-giving and teaching was accompanied by authoritative phrases such as "*not to follow bad lifestyle habits*" and "*correcting patients' health knowledge*". On this basis, it can be argued that the imbalance in power between nurses and patients, together with a lack of participation and negotiation, might generate disempowering effects and thus the possibility of resistance. That is, changing individuals' behaviour is a problematic and complex

task. Not only might it lead to victim blaming but also to “cognitive dissonance” as highlighted by the cognitive theory of health promotion (Festinger, 1958).

Another participant pointed out further that the perceived role in health promotion means helping patients to be responsible for their health:

“ I think that health promotion means being able to convince patients to take a responsibility for their own health and [thus] get healthier” (medical senior nurse 4)

Such a response is indicative of recognition of the patient’s potential role in the involvement in decision making concerning their health. This might have positive effects on self-esteem as well as adherence to the plan of care. However, considering individuals to be solely responsible for their health might introduce ethical issues such as victim blaming. This is an issue of concern particularly in the absence of facilitating factors (e.g. social support and counselling). The lack of recognition of broader issues might interplay with individuals’ own decisions (e.g. illiteracy). In other words, these findings do not sit comfortably with the principles of the empowerment model. That is, individuals are empowered to make informed choices in light of the facilitating mechanisms that allow this to happen (Tones and Green, 2004).

In brief, findings showed that the majority of nurses were confused about health promotion and health education. They were perceived as alike and used interchangeably without reflection on their ideology. This evidence is substantiated by findings created by the questionnaire. The activities carried out in the name of health promotion were inextricably linked to the way in which health promotion is understood by nurses. That is, offering health knowledge in an endeavour to change the behaviour and lifestyle of patients with no clear consideration of wider issues of what health promotion involves (e.g. participation and socioeconomic factors).

Little evidence is indicative of recognition of the importance of the individual’s role in making decisions about their health. This limited view of health promotion was

reported in previous nursing studies (Cross, 2005, Casey, 2007, Irvine, 2007). However, due to the absence of references to potential interplaying issues and facilitating factors outlined above, seeing individuals as exclusively responsible for their health was deemed as inappropriate in this analysis.

7.4.2 Macro-role of Health Promotion

In the second category, the analysis revealed that there is a more advanced development in nurses' understanding of health promotion and their reported activities in terms of aim, content and target. However, this development was based on the little response generated by the participants (n=3). One participant disagreed with her colleagues and viewed health promotion and health education as the same.

“I do not agree with this [health promotion and health education is the same], I think that health promotion means empowering patients to prevent illness and to adapt to it for the rest of life. Health education is part of it. It means providing patients with the knowledge needed to take into account their illness” (senior medical nurse 6)

“that is right, also health promotion means respecting patients' personal decisions despite conflict with their health status” (senior medical nurse1)

The above findings revealed that both empowerment and health education are a legitimate part of health promotion. It is worth noting the emergence of significant words/phrases in health promotion which focus on long term goals. This includes “adaptation” and “the rest of life”. This is indicative of a recognition that health promotion work and its components move beyond the focus of patients' recovery in hospital within a certain period of time. Indeed, it can be hypothesised that successful adaptation might enhance an individual's self-esteem, particularly when it is reinforced by empowerment principles (Webster and French, 2002). Conversely, the adapting man theory argues that the failure of adaptation is likely to lead to failure of self-actualisation (Dubos 1965). However, this good example of health promotion is

confined by the clear referral to illness and the absence of other principles of health promotion. This includes multi-disciplinary collaboration and other factors contributing to “adaptation” such as the socio-economic environment.

Whilst earlier findings show that health knowledge aims to correct patients’ knowledge and behaviour, the second extract points out that the key benchmark in health promotion is respecting individuals’ decisions. Doing so might eliminate the threat to the autonomy of individuals and thus encourage them to express their needs without reservation. That is, in order to clarify values and beliefs of individuals, dialogue rather than prescription is needed to neutralise the power between them (McQueen, 2000, Canter, 2001). However, it should be remembered that the respect of individuals’ decisions were stressed by a few number of participants.

A further wider issue expressed in the meaning of health promotion is health policy. This is reflected in the following extract:

“Health promotion means effective health policy. For example, hospitals in recent years prevented smoking within the hospital which is good. Good health promotion needs health polices” (medical senior nurse 5).

The above dimension of significance to health promotion was already mirrored in surgical nurses’ interpretations of health promotion. Although the recognition of a health policy as an element of health promotion was reported by the minority, it is a positive signal of a more holistic and complex understanding of its nature. Such a finding is promising and consistent with the broader understanding of health promotion (Tones and Tilford, 2001, Seedhouse, 2004).

It is worth noting however that the health policy was only linked to smoking within the hospital setting as opposed to the local community (e.g. preventing smoking in public areas). It could be suggested that nurses’ wider understanding of health promotion has a localised focus as opposed to the national level as urged by the

philosophy of health promoting hospitals (WHO, 1997). A final point is to be made here is that the reference to health policy was not associated with a systematic awareness of socio-economic factors and cultural beliefs at which health promotion is believed to operate (Rafael, 1999, Phillips, 2002, Parker et al, 2004). Therefore, whilst the macro-role in health promotion seems to be more cognisant of the complexity involved, it did not meet the principles and expectations of recent theoretical literature in this area.

7.5 Images of Health Promotion among Patients

Following the discussion about the meaning of health, participants were asked to offer their understanding of health promotion as well as experiences. Once again, many responses have emerged in response to the question about the meaning of health. Thus, themes of relevance to the question were re-organized and checked by the theoretical background of this study. The analysis revealed a wide range of responses and often they were inseparable. For the sake of clarity they are explored separately. Three key images of health promotion were found in the transcripts. With supported evidence they are given below.

7.5.1 Health Promotion as having Adequate Health Knowledge

Of all participants (n=23), 15 (65%) perceive health promotion as being armed with the necessary health knowledge. More specifically, desirable knowledge is about “medical treatment”, “infectious diseases”, “how to prevent illness”, “medicine” and herbs”. From the offered responses it was possible to identify certain knowledge seeking behaviour. As such activities were integrated spontaneously in their responses, they might be indicative of the real health promotion practice as they perceived it. Reading books about health and asking experts such as nurses are commonly cited activities. The analysis indicates that participants believe that being knowledgeable about medical health is a stepping-stone for enjoying life.

In this context, health promotion was perceived as a window through which health knowledge can be seen. This image of health promotion was expressed by both surgical and medical patients regardless of their gender.

“I believe that health promotion is offering people health knowledge... not all of us are aware about illness and its treatment (medical male patient 1).

“Yes- also giving us medicine as prescribed is health promotion (medical male patient 2)

Interestingly, other participants (n=5) introduced two elements to the health knowledge: “learning” and “teaching”.

“I think that health promotion is learning from your experience as well as other patients” (medical male patient 3)

Passing on knowledge from a knowledgeable person to the wider community is also a feature of the learning process (as perceived).

“.....[HP] is reading books about how to improve your health... I buy books about herbs and food...I am the family doctor now! I give health information to my family and sometimes to my neighbours (surgical female patient 2).

To a lesser extent, another participant did learn from the illness of her husband:

“ I learned more from my husband who suffers from cancer. I know many drugs now and I can teach people!” (Surgical female patient 1).

Further analysis suggests that learning from the media is an additional source of health knowledge. Such sources could help them to correct some questioned cultural practices:

“...[HP] is the ability to change some wrong cultural practices... certain herbs are toxic. I saw on TV last time that some elderly believe that all herbs have a magical effect! (Medical female patient 2)

Whilst the need for health knowledge was expressed differently, responses were underlined by one notion, i.e. being aware of illness and its treatment through developing a health database of knowledge. Thus, it was taken for granted as a protective mechanism against illness. Participants felt that the more knowledgeable you are, the more capable you will be of protecting yourself from illness. The above is consistent with the rational theory of health promotion which assumes that clients will make rational decisions based on their view of information given to them (Baird, 1998).

However, no evidence was found to indicate that participants were cognizant of the complexity of health and thus health promotion. Related to this, it seems that health knowledge was not seen as a vehicle to promote positive health by focusing on resilience and the growth of life skills. The focus on health knowledge might not only be related to their situation as already medically ill people, but also to the role of nurses as health promoters.

Interestingly, these findings are consistent with the majority of nurses' understanding of health promotion as well as what they do in its name (See above). That is, giving health information to prevent complications and to persuade patients to comply with the prescribed treatment. It is possible therefore that patients were influenced by what nurses often do (and focus on) during their interaction with them. This is verified by recurring extracts such as “knowledge about medicine and illness”. On this basis, it can be argued that perceiving health promotion as having health knowledge is a mirror image to nurses' micro-role in health promotion exemplified by information giving.

Giving health advice to other people might be a coping mechanism of hospital nurses. However, evidence reveals that participants developed their understanding of

health promotion as having health knowledge from their own family's experiences. For example, this is evident by the reference to learning from "*the ill husband*".

Findings worth consideration are the role of patients in their families and communities. Whilst the aim of this study is to examine nurses' role in health promotion, ironically it seems that participants themselves were interested in health education issues. Being health educators to other people such as neighbours informed the way in which health promotion was understood.

The above suggests that women in this study work towards self-actualisation by meeting the care needs for their families (Maslow's model, 1976). Their role as health educators or healers might be linked to the lack of women's economic dependence. That is, as explained in the next section, their role is to offer care to the family while men as breadwinners are responsible for financial issues.

However, focusing exclusively on medical care related issues within the family might detract attention from the wider issues of promoting an environment inducing health (Tones and Tilford, 2001). A cross analysis of focus group discussions generates further findings. It was found that being a health educator for the family and other people linked only to female participants. Whilst male patients were concerned more about learning about health, female patients were interested in both learning and teaching others. As the case with earlier research (Maddox, M. (1999, Yoho and Ezeobele, 2002), this might be explained by the motherhood situation in which older women in Jordan teach their daughters how to cure illness in the future. That is, they pass on health knowledge from one generation to another.

7.5.2 Health Promotion as Meeting Individuals' Economic Needs

In congruence with evidence suggesting that some patients perceive health as being economically independent, health promotion was also understood from this point of view. This image reflects 27% (n=6) of participants. Elements addressed under this image involve two key abilities: "*the ability to buy good quality of food*" and the

“ability to get *the medical treatment needed*”. Thus, it appears that the impact of economic constraints on patients’ interpretations of health and health promotion should not be underestimated. This is encapsulated in the following extracts:

“[HP] means the ability to get the medical care needed to overcome health problems... if health insurance covers each one then our health is promoted. Thinking about how to pay the cost of your treatment makes your health worse (Surgical male patient2)

“I agree with this. [it] means being able to buy good things that improve health.. fresh food and not cheap-quality” (surgical male patient 3).

Likewise, it was found that participants argue that having adequate money would enable them to buy good food and thus promote their health.

“[HP] means you are able to buy fresh meat and not frozen. This might cause you some problems and [thus] would not promote your health” (surgical female patient 2)

“...when you have sufficient money you can go to private hospitals where they offer you good care. This would make your health better” (surgical male patient 3)

Whilst social and psychological health was found to be related to patients’ understanding of health, both were not given attention when health promotion was discussed. It was felt that talking about health and economy was occupying the concentration of participants. This is not to say that other aspects of health were ignored. It seems that participants prioritized “economic health” over other aspects because of situational factors. Some of them (n=4) had problems from their previous admission with paying the cost of treatment. This stressful situation might inhibit individuals from reaching the self-actualisation status (Pender, 1996, Ewles and Simnett, 2003).

In the Stress Model and its effect on health by Lazarus and Folkman (1984) attention is paid to processes and changing the interplay between the individual and the environment. They claim that one's reaction in any given situation depends on the conception of the situation itself. According to the theory, the feeling of ability to control a situation is the most important factor for the re-education of stress and enhancement of personal well-being. In this analysis, it would appear that patients, mainly men, had no or little control over their poor financial situation and as one participant stated: *"Thinking about how to pay the cost of your treatment makes your health worse"*.

Nevertheless, the link between health and economy as a perceived health promotion is underlined by one key theme that is, having adequate money to overcome medical issues and buying health enhancing food. No links were made between good economic status and entertaining activities (e.g. travelling). Such activities are part of social life and might promote health. Keeping the classic Maslow's model (1976) in mind, it seems that participants were more concerned about fulfilling their basic and physiological needs. That is self-actualisation has a basic dimension.

Interestingly, no evidence was found to suggest that female patients perceived health promotion from an economic perspective like their male counterparts. This is surprising as some mentioned earlier that health promotion means eating healthy food. However, no reference was made to the economic ability to buy good quality of food in Jordan. Such economic ability is mainly the responsibility of men who are supposed to be the breadwinners. It should be noted that many of the female participants were housewives (n=11) and thus likely to expect their husbands to take up the financial responsibility. Therefore, these findings are indicative of the complexity of health promotion work i.e. interrelated roles and different needs to consider at the same time. Nevertheless, as the case with this study, the majority of nurses' perceptions and experiences of health promotion did not capture wider issues of health promotion such as economic status (Cross, 2004, Furber, 2000, Casey, 2007). The above findings are indicative of a recognition that meeting only patients' health education needs is not enough. The importance of above overlapping

elements are consistent with evidence indicating that a top-down, epidemiologically, driven approach often fails to achieve its goals (MacDonald, 2000).

7.5.3. Health Promotion as having a Good Environment

Whilst some participants were cognisant of the impact of economic factor on health promotion, very few participants (n=2) considered environmental issues. A close examination of responses found that viewing health promotion from the environmental perspective involves two meanings: “physical environment” and “spiritual environment”

Each meaning encapsulates two elements. Whilst the first was linked to the environmental pollution and diet free of chemicals. The second was associated with fatalism and praying. These are the features of the twin extracts:

“ ...[HP] is for all the community - we need good environment without vehicle emissions. Also, it means [healthy] food. Today's vegetables are full up with chemical stuff that is used by farmers. This could have a negative affect on our health” (medical female patient 5)

“...[HP]means the ability to accept your health problem as it is your fate. As now I accepted this, I feel more relaxed especially when I pray) “medical female patient 6).

The above responses highlight the importance of the religion and spirituality to Jordanian participants. In congruence with the study of Khalaf and Callister (1997), it was found that spirituality and religion were important influences on people's health in Jordan. Whilst in the west religion often does not have wide impact on people's health, it is a part of daily lives in the case of the followers of Islam (Rassol, 2000). Yet, the existing models/frameworks for health promotion largely originated in the west and thus they might not be applicable to the Jordanian context. It seems that there is a need to develop a more cultural and spiritually-focussed framework for health promotion in Jordan. This is to be developed in the discussion chapter of this thesis.

In addition to the spiritual dimension of health promotion, the above findings are recognition of wider levels at which health promotion operates (Tones and Green, 2004, Seedhouse, 2004). That is, taking into account the nature of the environment which might foster health gain. It should be remembered that the need for healthy food was not only linked to the meaning of health but also to health promotion. This again was reported only by female participants. This lends validity to the conclusions indicating that women's possible main role as housewives might draw their attention to issues related to such role.

Whilst health policy and regulations were not specifically mentioned, the reference made to the "*farmers*", "*chemical stuff*" and "*all the community*" could underline such wider issues. However, due to the lack of data, the former postulation needs to be taken with care. On this basis, "health policy" was not considered in its own right as an image of the perceived health promotion. Indeed, interesting findings to note are the emergence of cultural and spiritual practices as elements integrated into the ideology of health promotion. It seems that such practices contribute to the overall individuals' positive health focusing on building the capacity and resilience which in turn might maximize their well being (Katz et al, 2002, Chaves et al, 2005, Bowling, 2005). These findings substantiated evidence reported by a few nurses pointing out that spiritual health and fatalism might shape patients' understanding of health and thus health promotion. In line with this evidence, it should be noted that the cognitive learning theory of health promotion suggests that when the health education message is in conflict with patients' beliefs and attitudes, they react in a manner that could create dissonance (Festinger, 1958). Thus, there is a need for a framework of health promotion that integrates patients' beliefs in general and particularly those related to religion within the daily philosophy of care.

In summary, the analysis of responses about patients' understanding of health promotion and their experiences shows three images. These are, health promotion as having health knowledge, being economically stable and enjoying a free of pollution environment and spiritual life. Although the above images were explored separately,

they were closely interconnected. Related to this, it was found that physical health is often the ultimate goal of a stable economy and healthy environment. Together with gender issues, the nurses' own role in health promotion as well as situational economic burdens might play an instrumental role in shaping their understanding of both health and health promotion.

7.6 Patients' Views towards the Role of Hospital Nurses in Health Promotion

The analysis of responses about nurses' role in health promotion reveals a division among patients. Whilst many (74% n=17) acknowledge such a role, others express their disagreement (26%, n=6). Further analysis attempts to identify factors affecting their agreement or otherwise. It was found that good communication skills, having more medical knowledge and being close to the patients were prerequisites for acknowledging nurses' role in health promotion. It is not surprising therefore that a health behavioural change approach is ineffective unless the outcomes are based on empowerment, collaboration and patient led strategies (Harm 2001, Caelli et al, 2003).

The above findings are the features of the following extracts:

"I believe that doctors are the most suitable staff to promote our health" (medical female patient 1)

"I agree with this, they know more than others". (Medical female patient 2)

"Yes- doctors do the operation and can promote our health properly" (medical female patient 3).

"Nurses have a role [in health promotion] but it is limited. They do not talk about health issues unless you ask them and sometimes they do not give you a clear picture". Some, they don't even talk to you properly" (medical female patient 4)

The opposite views represent positive attitudes towards nurses' roles as health promoters:

“They [nurses] have a good role in making patients’ psychological status better... When they get in your room smiling and talking to you as you are one of their family members, I feel more relaxed” (medical male patient 1)

“Nurses are very good in promoting health. For me the most important thing is vena puncture and nurses do it very well without pain” (medical male patient 2)

“I think that health promotion is talking with patients nicely... nurses are really nice in this ward. Sometimes I ask for something but they do it for me quite late due to the lack of time and increasing workload, [then] they apologise for that (male medical patient 3).

“I am a regular customer to the hospital!! I think that nurses are in a unique position to promote patient’s health. You see them regularly whereas doctors come only for ten minutes” (male medical patient 4).

The above findings add further illumination on nurses’ role in health promotion. It is interesting to note that the way in which communication is established with the patient might have a profound impact on their engagement in nursing health promotion work. Thus, accepting nurses’ role in health promotion. However, in light of evidence reported earlier in this chapter as well as previous studies (Davis, 1995, Furber, 2000, Cross, 2005,) communication is often characterized by an expert-led nurse approach as opposed to a collaborative and negotiating approach. Thus, participants felt that the more skilful you are in communication, the more likely you are to be a good health promoter . Therefore, an encounter that is empowering in its nature and fosters self-worth is likely to result in positive health promotion outcomes (Daiski, 2004).

Whilst the potential difference between nurses and doctors in terms of medical knowledge is perceived, prioritizing doctors over nurses when it comes to health promotion might be explained by the level of given power within the organization. Given their strong decision-making position, doctors might be seen by patients as

more effective helpers. For example, as some patients' perceive health and health promotion from an economic point of view, patients might feel that more powerful people are preferable to address such more complex needs. That is, patients' views towards the role of nurses in health promotion might be influenced by the organizational atmosphere where the imbalance in power created superiority and inferiority among medical staff. Likewise, although there is a lack of evidence from patients, the low public image of nursing as reported by nurses might contribute to some patients' views about their role as health promoters. These factors are to be explored systematically in chapter 10.

7.7 Hospital nurses' role in health promotion from the perspective of ward supervisors, the nursing educator and the nursing manager

Data related to the nurses' potential role in health promotion were derived from a number of items included in the interview schedule with ward supervisors (n=2), the manager of training and development and the nursing educator (See appendices 2, 3, 4.). According to the supervisors, their main role is to ensure the delivery of high standards of care at ward level. They are engaged in the process of nurses' recruitment as well as issues related to the availability of medical equipment in the area they supervise. In response to the question regarding what nurses do in relation to health promotion, supervisors expressed dissatisfaction. They pointed out that in the current situation nurses' role in health promotion is limited. Whilst the responses were different, they were largely underlined by a key theme, that is, an orientation towards the treatment of illness as opposed to positive health. As shown below, ward supervisors pointed out that the medical treatment and related issues are the focus of the current practice of nurses on surgical and medical wards. Elements found in the analysis to reinforce that are: "preventing illness", "acute pain management", "and giving medicine". These findings are illuminated further by the following extracts:

"Health promotion in this ward [means] preventing illness and treating certain health problems. It is [concerned] about preventing complications.....the main

aspect of health we pay a lot of attention to is giving medicine and pain management -sometimes we use 20 ampoules of Pethedine per shift” (surgical ward supervisor)

Within the context of medical approach to health promotion, similar themes were found in the data from the interview with the medical ward supervisor.

“Health promotion in this ward is limited. We offer patients health advice about medicine and medical procedures. We receive already ill people. We need to ensure that patients will comply with the prescribed treatment at home. Some elderly were readmitted in the past because they did not adhere to the medical instructions (medical ward supervisor).

As outlined above, the role of health promotion at ward level largely revolves around medical care. The activities reported can be located at the level of health of education as exemplified by information-giving as opposed to health promotion operating in wider issues. For example, not only were broader components of health advice absent (e.g diet and stress) but also no mention was made of empowerment as an element which needs to be accompanied by educational activities (Tones and Green, 2004). That is, the exclusive focus on individuals’ behaviours might detract attention from the wider issues of promoting an environment inducing health (Whitehead, 2003).

Likewise, it seems that a family centred approach to health promotion was missing from the framework of health promotion at ward level. This is an important issue as in Jordan the extended family system is popular and health decisions are made within the family context (Haddad, et al 2004).

No evidence was found to indicate the active involvement of the family when health education activities were offered to patients. Whilst health education is part of health promotion (Tones, 2001), the finding is not consistent with previous studies (Yoho and Ezeobele, 2002, Hjelm, et al 2005), nor with the patients’ perception of health in this study focusing on social aspect affected by their families.

It is worth noting however, that the exclusive aim of health advice is to enhance the compliance of patients to the medical treatment as opposed to fostering independency, self-growth and responsibility. Although such an approach might lead to better health, it does not necessarily lead to rationalised decisions due to the complexity of the change process. In line with this and the cognitive dissonance theory of health promotion, (Abramson et al, 1978), it is argued that some individuals might not accept the advice even with convincing evidence that their behaviours are harmful to their health (Cole, 1995). Thus, patients in the current analysis might adhere to their own agendas and continue with damaging health behaviours with or without a health professional's advice.

The second extract suggests that patients are urged to adhere to the medical advice but with no attention given to the availability of mechanisms enabling this to happen (e.g the absence of social support, literacy, economic constraints). Thus, responses lacked reference to actually dealing with or reducing barriers that could interplay with individuals' informed decisions whether on the ward or at home.

Although there is a lack of data, this is an ethical issue for patients as they might be blamed for not adhering to health advice without taking into account wider issues such cultural beliefs and structural constraints (Whitehead, 2002, Seedhouse, 2004). On this basis, whilst it appears that the health education role is in operation at ward level, the complexity of influences involved is not acknowledged. Simply, responses did not show that ward supervisors were cognizant of the current global development in the health promotion field. Related to this, no reference was made to key principles such as partnership, negotiation, advocacy and lobbying at which health promotion is argued to operate (Piper and Brown, 1998, Seedhouse, 2004, Tengland, 2006, 2007). However, these findings match the way in which health promotion is perceived by nurses (See Chapter 7, sections: 7.3.1, 7.4.1). Thus, interview data lend validity to the overall development of nurses' role in health promotion. That is,

a role largely guided by the medical approach to health promotion and the ideology of health education.

Evidence from collected data indicates the lack of understanding of health promotion and health education. At the time of the interview, ward supervisors used the concepts interchangeably. Thus, the researcher asked them to elaborate further on the meanings attributed to health promotion and health education. It was found that responses were masked by confusion about their meaning and potential differences. This is reflected below:

“Health promotion or health education is preventing illness and treatment...”

(Medical ward supervisor)

“Health promotion and health education are the same as giving health advice..”

(Surgical ward supervisor)

These findings highlight the hesitancy and lack of clarity of the ideology of each concept. It is interesting to remember that evidence from the questionnaire found that the majority of nurses (78%, n=45) considered health promotion and health education alike. On this ground, it can be argued that the overall limited role in health promotion on wards might be as a result of conceptual understanding of health promotion and health education themselves. The lack of reflections on what constitutes health promotion was found in nurses’ as well as supervisors’ perceptions and confirmed by previous research (Davis, 1995, Furber, 2000, Irvine, 2007). The extent to which this might shape the role and thus the practice of health promotion should not be underestimated.

Complementary evidence indicates further that whilst the nursing educator was more optimistic about the graduate nurses’ role in health promotion, her counterpart was dissatisfied. This is exemplified below:

“...I think that graduated nurses [RNs] are [qualified] to play a role in health promotion in the future. They need to [improve health] of different age groups and communities..” (Nursing educator)

“ .. I think that their role [hospital nurses] in health promotion is limited. Only those nurses who have further education such as in diabetes pay attention to this role. The role of nurses on wards in health promotion is poorly developed. For example, we do not have [a definite] discharge plan. We talk very briefly about what to do at home and who to contact in case of emergency. We know that this is not enough but we have no options”
(The manager of training and development).

These findings are indicative of the lack of consistency surrounding whether or not hospital nurses are capable of playing an instrumental role in health promotion. Related to this, the above extract would lend validity to the lack of a systematic approach to health promotion for certain opportunities such as the discharge time. It seems that such a transitional time for patients from hospital to home is largely informed by an expert-led educational approach as opposed to multidisciplinary and empowering model for health promoting encounters (Pender, 1996, Tones, 2001, Daiski, 2004). Indeed, whilst the discharge intervention is not informed by a standard guideline (see the above extract), it happens somewhat haphazardly focusing on what patients should do and not to do at home. This is to be explored further in light of observational findings given in chapter 8.

7.7.1 Across-analysis of Interviews

Although the overall evidence reveals that the current role of nurses in health promotion is constrained to medical approach based health education activities, to a lesser extent, across analysis shows some differences. Whilst the number of ward supervisors in this study is very small (n=2) to enable a systematic across-analysis, the evidence from their interview is complementary to other datasets rather than primary (Gillis and Jackson, 2002). That is, in the constructivist case study design, the aim is to produce constructs of the reality from the point of view of various perspectives that then add depth and breadth to the overall conclusion (Denzin, 1994, Yin, 2003, Fisher and Ziviani, 2004).

Examination of responses found that medical wards are more concerned about psychological and social health than in surgical wards.

This is illuminated further by the following extract:

“ [in medical wards] psychological support is a fundamental element of health and we give it a lot of attention. We spend significant time with those patients suffering from multiple health problems such as diabetes and hypertension. We help patients to explore their concerns and encourage visitors to keep in touch with them. We try to make this ward as [friendly as possible]” (medical wards supervisor).

Indeed, the impact of relationships between nurses and patients in care and thus health promotion was recognized by the medical ward supervisor:

“ ... therapeutic relationships between nursing staff and patients in medical wards is often strong. They sometimes spend months in the ward and the relationship between them and nursing staff gets friendlier. This is good for any health promotion activities such as teaching patients about medicine and the treatment plan they will go through” (medical wards supervisor).

These findings are indicative of recognition of the complexity of different aspects of health. In other words, it seems that health is perceived more holistically in medical wards. It is interesting to draw attention to the fact that previous findings reveal that medical nurses were more aware and sensitive to psychological and social aspects of health in comparison to their counterparts in surgical wards. Therefore, the above evidence confirms that health is viewed more holistically on medical wards. As suggested by previous research (Davis 1995), nurses in the surgical ward are often too busy to offer immediate medical care and pain relief to their patients. On the other hand, the nature of medical cases that need frequent admissions might enable medical nurses to pay greater attention to wider determinants of health than to focus exclusively on medical care. That is, unlike surgical nurses, medical nurses might

have better opportunities to develop a therapeutic relationship with patients and thus deliver health promotion work driven by the empowerment model. Such a model of health promotion does not only foster self-esteem of patients but also the interaction derived by the partnership approach clarifies their values and beliefs and thus neutralise the power between patients and hospital nurses (McQueen, 2000, Canter, 2001).

Nevertheless, whilst empowerment was not mentioned explicitly in the data, scholars argued that the good relationship with patients could empower them and thus maximise patients' self-actualisation and independency (Tones and Green, 2004, Casey, 2007). By establishing a trust relationship, cultural beliefs and patients' receptivity to health promotion might be better identified and addressed (Smaje, 1995, Gallant and Dorn, 2001, Kim-Godwin, et al 2001, McBride, 2004). Moreover, findings suggest that there is a positive link between the length of hospitalization and the possible delivery of any health promotional activities.

Briefly, although a cross analysis reveals that health promotion could be better developed in medical wards (see above), the overall nurses' role at the ward level in health promotion was not up to the expectations of the modern ideology of health promotion. This is reinforced by the lack of recognition of structural and political influences that could form the grounds of health promotion work. However, evidence reported in this section offers a valuable tool to examine the extent to which findings are validated by other methods. It seems that the framework of health education as opposed to health promotion was in operation at the time of data collection. This postulation, however, needs to be taken carefully in the light of contributing factors presented elsewhere in this thesis.

7.8 Summary of Hospital Nurses' Role in Health Promotion

This chapter addresses findings related to the overall perceived nurses' role in health promotion. Complementary and confirmative findings regarding the hospital nurses' role in health promotion were also offered by patients, interviews with ward

supervisors (n=2), the manager of training and development as well as the nursing educator.

In view of emanating findings in relation to the content of health promotion, its aims and target, it was decided to address them under either “micro or macro role in health promotion”. Evidence suggests that the majority of participants particularly those who work in surgical wards, are guided by the characteristics of the micro-role in health promotion. The analysis revealed that these characteristics involved a cluster of elements including: - an exclusive focus on patients with no attention to wider issues that might interplay with their health or offering patients health knowledge in order to change their lifestyle with no reference to empowerment and participation.

Whilst this might paint a dark picture about nurses’ roles in health promotion, evidence equally indicates that nurses, despite being in the minority, were cognizant of some complexity and comprehensiveness of both health and health promotion. Their responses were indicative of recognition of health policy, empowerment and individuals’ freedom of choice and being sensitive to their cultural and religious beliefs. These elements are congruent with the recent health promotion ideology (WHO, 1997, Tones, 2001, Seedhouse, 2004). Nevertheless, these components had a localised focus on hospital borders as opposed to the wider community at national level. Indeed, other principles at which health promotion operates were missing (e.g. equity, advocacy and multi-disciplinary health promotion work) (Whitehead, 2005).

Due to the nature of focus group discussions, it can be argued that the small number of participants and the group effect might threaten the generalisation of the above findings. Whilst this is acknowledged in this work, the quantitative evidence from the questionnaire offers further complementary evidence. The majority of respondents (78%, n=45) felt that health promotion is the same concept as health education. Those who believed that health promotion and health education are not the same (22%, n=13), failed to point out a definite difference. However, their responses lend validity to the conclusion offered by the focus group discussions with nurses and individual to individual interviews (see above). That is, what health

promotion means can be addressed by the framework of health education focusing on offering health knowledge which aims to change individuals' unhealthy lifestyles.

The link between the way nurses understand health and health promotion has been narrowly addressed in previous research (Herberts and Eriksson, 1995, Haddad and Umlauf, 1998, McBride, 1994, Furber, 2000, Cross, 2005, Casey, 2007). In this chapter, it seems the impact of such a link should not be underestimated. The perceptions revolved around health mirrored by those expressed about the meaning of health promotion. For example, being able to function physically as a view of health was associated with preventing illness as a perception of health promotion.

In other words, the confirmative evidence from the current and the previous chapter shows that nurses' perceptions of health promotion largely fit with their views towards health. In light of this, it is unwise to expect a more advanced conceptualising of health promotion while nurses are not fully cognisant of the multidimensional concept of health.

Although nurses and patients perceive health promotion in a similar way (e.g. preventing health problems), there is a discrepancy related to economic issues and spirituality. This relates to the absence of the economic dimension of both health and health promotion (confirmative triangulation). In fact, spirituality was seen by some surgical nurses as a barrier to health promotion work in a way that might encourage patients not to follow a certain treatment plan. Whilst changing individuals' behaviours is a problematic and complex task, the process might lead not only to victim blaming but also "cognitive dissonance" as highlighted by the cognitive theory of health promotion (Festinger, 1958). This means that patients are likely to resist health advice when it contradicts their spiritual beliefs (Van Leeuwen and Cusveller, 2004). That is, health promotion is influenced by staff's knowledge and the norms of those who will be targeted (Groene and Jorgenson, 2005).

Thus, health promotion components (at least health education) might not comprehensively address patients' needs. Subsequently establishing culturally

congruent health care as well as health promotion activities will not be effective (Higgins and Learn, 1999, Kim-Godwin et al, 2001McLennan and Khavarpour 2004).

Finally, the analysis reveals that there is a separation rather than integration between health promotion and the nature of care being delivered. Thus, it was postulated that nurses had no time for health promotion as they perceived it as an added activity to their workload. Based on nurses' perceptions and stories, it was possible to draw evidence about what they do in the name of health promotion. However, it is argued here that perception is not enough to draw a more holistic and robust picture of evidence. That is: there is a need for observational findings to reflect the reality of nurses' practices.

Chapter Eight: Hospital Nurses' Practice of Health Promotion

8.1 Introduction

Whilst previous chapters theoretically examine hospital nurses' role in health promotion and related experiences, this chapter presents findings surrounding the development of nurses' practices in health promotion. It sheds light on what nurses do in the name of health promotion as well as those contributing factors affecting the practice. Twenty discharge interventions (10 in surgical wards + 10 in medical wards) as well as 20 medical rounds were observed.

The discharge plans enable hospital nurses to act from a health promotion perspective as they need to offer support and knowledge to ensure patients remain independent and well at home (Smith and Cusack, 2006). On the other hand, medicine rounds were suitable to explore patients' cultural beliefs, family involvement and any element related to empowerment such as fostering independence (Callaghan, 1999).

The inclusion and exclusion criteria, included only those patients who were both physically and psychologically able to communicate. Some patients with a previous psychological problem identified by doctors and senior nurses were excluded. It was felt that including them might affect the dynamic interaction with nurses as well as the reliability of any health promotion behaviours. Indeed, only patients who were hospitalised for at least a week were selected. This is in order to ensure that they have experienced significant encounters with nurses and thus offer in-depth data. (See Appendices 8 and 9). Having produced the list of eligible participants, they were randomly selected. The observations were carried out in different shift patterns in order to consider the workload which is likely to be intense in the morning. For more information about the observation, associated problems and access to participants, See Chapter 4, section 4.6.2.1).

Whilst observing the interaction between hospital nurses and patients during such encounters (medicine rounds and discharge time) might represent only a snapshot with little or no information about the previous encounter, two issues need to be

considered. Observational findings in the current study are analysed in light of evidence generated by other data sets particularly those produced by focus group discussions with patients. Secondly, it should be noted that empowering approach to health promotion does not only foster self-efficacy and self-esteem (Tones and Green, 2001) but also the interaction derived by the partnership approach as opposed to an expert led and top down approach of communication can take place in any daily encounter with patients (Whitehead, 2004). Likewise, in order to clarify values and beliefs of individuals, dialogue rather than prescription is needed to neutralise the power between them (McQueen, 2000, Canter, 2001). Thus, these principles might be examined in every encounter between nurses and their patients.

Indeed, a further four teaching and assessment encounters between nurses and diabetic patients were observed. The inclusion and exclusion criteria are similar to above.

Field notes about the context of observations were made and the conversation between nurses and patients were digitally recorded. In order to capture a more coherent picture about the practice of health promotion and health education, analysis was guided by utilising two approaches: inductive and deductive. Firstly, each observational incident was analysed separately in relation to the area of practice (e.g. medicine rounds in surgical wards). Secondly, cross-incident analysis was carried out between both surgical and medical wards allowing possible differences and similarities to emerge and thus to detect the pattern and the degree of practice development.

In the light of recent theoretical literature and debate about health promotion, two key categories were structured. It was decided to refer to the first category as “limited practice”, and to the second as “advanced practice”. This categorisation system was developed taking into account the framework of analysis reported in Chapter 4. More specifically, it was examined within the context of Vienna’s recommendations (WHO, 1997) which points out principles to guide the development of health promotion within the hospital setting. The following formula

by Tones and Green (2004) was also used to inform the constructional development of categories.

Health promotion = Health education + health policy

The limited practice of health promotion was more prevalent than advanced practice. It was found that 16 discharge interventions out of 20 (80%) and 14 medical rounds (70%) can be addressed under the first category, yet that quantification was introduced here, not to achieve a statistical generalisation, but rather to check the dominance of certain themes. The emerging themes are explored and evaluated to detect the degree in which health promotion is practised. Along with supportive justification, these categories and relevant elements are explored below. This is followed by a summary integrating and debating the link between hospital nurses' actual practice of health promotion and their perceptions and experiences outlined in previous chapters.

8.2. The Limited Practice of Health Promotion

The analysis has shown that nurses' practices under this category were lacking in the development of health promotion principles and health education skills (see below). These were either absent or minimal activities that can be narrowly considered as health promotion with its diverse components. The outcomes of practice were limited in terms of the target and the content of message. Individuality, as well as information- giving instigated by patients themselves are key features of this category.

It seems that when nurses attempt to promote the health of patients during their interactions, the medically oriented view of health dominates their practice. This is exemplified by an exclusive focus on patients as a collection of symptoms which need to be "fixed" as opposed to the holistic view of health focusing on holism and structural determinants of health. That is, the interactions are inconsistent with the modern values of health promotion and sit well with the individualised health education work (Tones and Green, 2004, Seedhouse, 2004). However, even the

health education role was constrained by the utilisation of an expert-led as opposed to collaborative communication approach.

This created a hierarchal interaction between two groups. A group armed by professional knowledge and another one guided by lay knowledge. Fundamentally, the nature of such interactions is not congruent with the framework of health promotion exemplified by the values of advocacy, participation and negotiation (Whitehead, 2005, TEngland, 2006, Casey, 2007). In this context, patients' freedom of choice and autonomy might be compromised and thus lead to a disempowering effect.

Evidence from findings suggests that the discharge intervention is often carried out in a mechanistic way. The doctor writes the discharge letter, the nurse gives it to the patients along with a bag of medicine and then the ward clerk checks any outstanding treatment bill. This pattern was often seen in surgical wards where the rhythm of work is fast and the demands on nursing staff are high. In order to establish a more coherent inductive analysis, observational data and field notes were analysed focusing on four issues: the process itself, the length, the location and the people involved. It was found that the average time for discharge intervention was about 3 minutes and often carried out in the corridor or in the nursing reception rooms. Analysis shows that patients themselves and nurses were the key people involved.

Whilst it is acknowledged that neither the time nor the physical environment were suitable for delivering any health promotion (e.g. understanding structural issues affecting the recovery at home), there were some missed opportunities for health education activities accompanied by the principles of health promotion (see below). Medical rounds were concerned with telling patients only what the medicine is for and how it should be taken. In some cases, informing patients and their families about medicine was as a result of their questions rather than by the recognition of nurses' own roles in health education. Overall, limited practice as a category has two manifestations:

- 1- Limited health education activities led by nurses.

- 2- The absence of health promotion principles in nurses' encounters.

8.2.1 Limited Health Education Activities

The analysis of observational data indicates that information-giving was the key health education activity during nurses' encounters with patients during discharge time and medicine rounds. This observational evidence confirms nurses' descriptions and perceptions of health promotion work as explained in chapter 6 (6.3,6.4) and confirmed by earlier work (McBride, 1994, Furber, 2000, Cross, 2005). This involves telling patients about the name of their medication (e.g. Ranitidine) and its functions. There is little evidence found about encouraging patients to participate in care and often they were submissive and passive listeners as opposed to active engagers. More specifically, empowering patients, fostering self-esteem, negotiating care and integrating a health policy into care were absent from the encounter (Tones and Green, 2004, Whitehead, 2005). Likewise, nurses often did not take feedback from the patient and their relatives about their understanding of a certain regimen (e.g diabetes and diet). Information-giving however was usually instigated by patients themselves with limited attention given to their background which might interplay with their decisions and thus compliance. These findings confirm questionnaire evidence suggesting that the majority of nurses (59%, n=34) consider health as a free of illness status. This could explain the poorly developed understanding of health promotion and the way it is translated in nursing practice. This is reflected in the following extract during a discharge intervention:

(The senior nurse carrying some medicine to patient and her family. The patient has an infected wound on her left arm)

N- Hi X, as you know, you are going home today. You need to pack up your belongings. This bag includes some medicine you have to take at home. The instructions are written on their covers.

P- Thanks- do I need to come back later?

N- Yes after two weeks, you need to visit the outpatient clinic to check the wound. If pus and a temperature have occurred you need to get in touch with us as soon as you

can. Now you need to go to the ward so the Clerk can finalise the discharge documents.

P- Thanks (Smiling and shaking hand with the nurse).

(recorded discharge intervention in surgical wards)

The above life evidence is an example of a limited health education activity in terms of the focus and approach. The content of the message has not moved beyond medically rooted health advice as opposed to positive health, focusing on fostering self-esteem and independency.

It is worth noting that the nurse assumed that the patient would be able to read and understand what was written on the medical packs. For instance, it seems that care is carried out in a fragmented way, lacking collaboration amongst professionals. As outlined in the above extracts, the nurse and nutritionists offer care separately in terms of educating patients. On this basis, it could be argued that nurses operate within the ideology of health education as opposed to encapsulating health promotion (e.g. empowerment and health policy). The role of both the patient and her family in the encounter was limited and passive rather than active and collaborative. This somewhat contradicts the theory of reasoned action (Ajzen and Fisherbein, 1980) arguing that the intentions to perform an action are determined by the individuals' attitudes towards the behaviour and the social norm influenced by the family structure. Although multi-disciplinary work is the bedrock of health promotion (Tones and Green, 2004), it seems it had not featured in the interaction. Related to this, other members of the medical team (e.g. doctors and other nurses) were not involved during the interaction to offer a more holistic and presumably effective health education message. Instead, the clerk of the ward was often the key person seen by the patient at the time of discharge. The implication however for patients' health and thus health promotion is limited. This is due to the fact that the main role of ward clerk is to ensure the full payment of treatment rather than promoting the health of patient. That is, those health professionals who could make a real health promotion contribution were absent from the encounter. This lends validity to the

earlier analysis in this thesis showing that inter-sectional and multi-disciplinary work and lobbying were absent from nurses' interpretations of health promotion.

In another discharge intervention, the nurse seems to have a friendlier approach and offered more detailed health knowledge.

(A surgical female nurse is in her way to carry out a discharge process to a 74 year old diabetic female patient).

N- Hi- you look brighter because you're going home with your family!

P- yes- finally I can sleep well!

N- smiling- did you have any problems while in hospital?

P – no- but I feel happier at home.

N- that is right- this is the discharge letter and antibiotic to take at home. \You know this time we did extensive wound dressing and you need to look after yourself very carefully from now on.

P- I will do- I did learn a good lesson this time and I will get my son to check my foot for any ulceration.

N- that is good. Also you can use a small mirror to see any potential ulceration. You need also to keep the area between your toes dry to prevent fungal infection.

P and her family: thanks a lot to all of you.

N- No problem at all, you are always welcome. You are like my mum.

(recorded discharge intervention in surgical wards)

Although the nurse would appear to be aware of her own health education role, the focus is only on physical issues as opposed to social and mental facets of health. The individuality and the lack of participation on the part of the patient and the family are evident. An interesting finding to note is the cultural and communication phraseology used. The term “*you are like my mum*” should not be seen as age discrimination. In fact, it is one of the preferable phrases used to communicate respectfully with the elderly in Jordan.

Given the gender of the nurse and the elderly patient's poor health, the use of the cultural phrase is of relevance to the concept of emotional labour. It is defined by

Hochschild, (1983) as the management of feeling to create a publicly observable facial and bodily display and in nursing it requires nurses to generate an emotional state in another person (Smith, 1992). It has traditionally been identified with women's work and the mother's role in the family (Gray, 2009). Indeed, it was a prime role of sisters and charge nurses (Smith, 1992). Within the context of health promotion, hospital nurses need not only offer health knowledge but also inform their framework of care by patients' narratives and interpersonal skills (Piper and Brown, 1998, Ellis and Bochner, 1999). Whilst this in its own right could aid the development of a relationship of trust and clarify values and beliefs of individuals (Canter, 2001), no further evidence was found in the previous interaction to suggest that it was used as a tool to explore the whole family's agenda and thus enhance positive health gain.

Observational notes found that the speech was solely directed to the patient as opposed to all family members. As a result a family-based approach to health promotion was missing (Pender, 1996). Likewise, the nurse assumed that the patient was already familiar with medical terminology such as "antibiotic" and "fungal infection". Consequently, not only were the principles of health promotion absent (e.g. empowerment and advocacy) but also health advice was given in a complex way that could be misunderstood by a lay people. This might contribute to the gap between health professionals' scientific knowledge and their patients' interpretations of health and advice (Zoucha, 1998) and in consequence affect the delivery of culturally competent health promotion work.

Although incidents are contextually different, the analysis of observational data from medical rounds reveals similar themes. The lack of participation and negotiation of both patients and their families was evident. Under the limited health education practice, no evidence was found to reveal that patients were given the right to accept or reject taking the prescribed medicine. As the nurse was accompanied by the current researcher, it was felt that giving medicine was guided by the notion of "get the work done". That is: it was task oriented towards treating illness instead of an opportunity to examine patients' needs, clarify values and discover cultural beliefs

and practices (McBride, 1994, 2004, Pender, 1996, Nawafleh et al , 2005). This is illuminated further by the following extracts:

(The medical nurse is about to give medicine to a male patient with an obesity problem)

N- Hi X- you need to take this tablet before you have your dinner.

P- ok- thanks. (patient and his family asked the nurse about the benefits of the tablet)

N- It is for lowering the cholesterol. Ok

Another nurse attempted to consider social issues while medicine is being given:

N- Hi Y. how are you today.

P- Good but it is very boring here.

N- Do you want me to turn the TV on? There is a nice comedian show on. By the way I have not seen your wife for a while.

P- yes- my wife lives quite far away from Amman and travelling here is not easy for her.

N- I see- this capsule is an antibiotic for your respiratory infection. Do you want cold water- it is boiling here!!

P- Yes please

N- Here you go.

P- Thanks. (recorded medicine rounds in medical wards)

Whilst the above encounters were brief in terms of time, they illuminate the extent to which nurses' roles in health promotion are featured in their practice. The health education role had emerged as a result of the patient's questions about the medicine, instead of an automatic response to information-giving. Although there is a lack of evidence, it could be speculated that the educational needs for those patients with communication problems (e.g. dysphasia), could not be met. Nevertheless, when information is to be offered, the interaction is informed purely by the medical approach to health education. This confirms nurses' medically driven perceptions of health promotion explained in chapter 7, (sections 7.3-7.4). Whilst this could be beneficial, other approaches to health promotion were not utilised despite being applicable to the encounter. For example, the behavioural approach was not considered although the interaction was with a patient suffering from health problems related to obesity. As shown in Chapter 3, more health approaches need to

be utilised when confronted with complex cases (Naidoo and Wills, 2000, Tengland , 2006).

No evidence was found to suggest that the complex patient's lifestyle as well as beliefs were explored. Thus, it might not be possible to establish interventions enabling individuals to change their health behaviour and arguably enhancing health gain. Likewise, the socio-environmental approach was not considered. It is not clear if the obesity was related to structural determinants of health such as unemployment as well as the lack of education.

Evidence from the second encounter indicates that the nurse was more skilful in terms of communication and the consideration of wider issues. It would appear therefore that some nurses had developed their role in health promotion better than others. Related to this, the above evidence indicates the utilisation of the idea of a social model of health exemplified by visiting patients and maintaining social relationships. This is consistent with Katz et al's, (2002) assertion that social health in specific cultures is exemplified by individuals' interpersonal interactions such as visits with friends and social participation which positively influence their health. However, attention given to the wider issues (social health) was limited and not inter-related to other aspects of health such as mental and emotional aspects. Indeed, the context of observations indicates that paying attention to the social aspect of health could be as a result of social chat with patients rather than recognition of its importance as an element of a holistic meaning of health. The timely limited encounters with patients during medical rounds and discharge interventions might be a contributing factor to the limited health education role.

Field notes reveal that nurses, especially in surgical wards, had a lot of things to do at the same time. This includes: supervising nursing students, participating in medical rounds, and giving medicine to a large number of patients (n=25-30). Whilst these factors are acknowledged, further observations indicate that nurses lacked health promotion and health education skills regardless of the length of interaction.

The analysis of non-participant observational data found that diabetic nurses spend about 25-40 minutes with patients. This time-scale however was not fully used as an opportunity to deliver health promotion activities operating at policy and structural levels. This is reflected in the following encounter which speaks for itself:

(The diabetic nurse preparing equipment for diabetic foot dressing)

N- Hi- how are you today? (The 62 year old was surrounded by her relatives)

P- I feel better than yesterday. I feel that there is something coming out of the dressing.

N- I will check it and change the dressing for you.

Patient's daughter: do you want us to leave now and let you do your work?

N- Yes-Thanks-

(They went and sat in the balcony) .

(The nurse started doing the dressing and there were many episodes of silence. the patient started asking the nurse questions about what is on the dressing trolley:

p- What is that yellow stuff?

N- It is local antibiotic

P- "Shook her head"

N- It seems better than before but it needs a couple of dressings later. Eating well is important to heal the wound.

P – ok- hopefully they will not chop it off one day. (Sad voice - staring at her bandaged foot).

N- Do not worry as long as you take medicine and we do the dressings, you will be ok. I will see you again tomorrow.

P- thanks-

The daughter of patient asked the nurse about her mum's foot in the corridor

N- it looks better, it needs more dressings.

(Recorded conversation in a surgical ward)

The above "show" illuminates further the limited health education role exemplified by giving information that alone might not be effective. Whilst the dressing itself was undertaken in a professional and aseptic technique, health needs were met in a

narrow way. Observational data and field notes suggest that not only was positive health focusing on self-growth and life skills absent but also health itself was fragmented.

Psychological and emotional aspects of health were marginalised in the encounter. Phraseology used by the patient “one day they will chop my leg off” was enough to stimulate further exploration of needs, concerns and beliefs. Thus, the opportunity to structure the ground for a health promotion strategy was missed by lost opportunities on the nurse’s part. Such findings are consistent with Bowling’s (2005) argument indicating that in health care, where clinical interventions are specific and invasive, most existing indicators about health are reflected in the medical model. Likewise, the findings confirm nurses’ medically orientated health promotion role (Furber, 2000, Cross, 2005, Casey, 2007). Indeed, it is worth noting that the interaction with the patient was not guided by a collaborative approach to multi-disciplinary work. For example, physiotherapist and nutritionist were not involved in establishing a more coherent health promotion activity that could be incorporated into the framework of care.

In brief, under the category of limited health promotion practice, the majority of interactions with patients were characterised by nurse-led information-giving activity.

The available evidence reveals that nurses during medicine rounds and discharge interventions were operating within a limited health education ideology. This is substantiated by nurses’ perceptions of health promotion outlined in Chapter 7 (sections 7.3.1, 7.4.1) and confirmed by previous studies (Cross, 2005, Casey 2007). That is, giving health information in an attempt to convince patients to comply with the prescribed treatment or in response to their questions. Yet, it would be naïve to expect individuals to change their behaviours due to the exposure to the scenario of the threat of illness and benefits of health (Whitehead, 2001).

The lack of collaborative work among health professionals created an unsupportive environment for delivering effective health promotion activities matching the needs of patients. On this basis, it can be argued that giving information was not used as a vehicle for empowering patients as urged by Ewles and Simnett (2004). These

findings are in line with the majority of nurses' perceptions of what they do in the name of health promotion as reported in the previous chapter. Yet, the reality is that the aim of health promotion is widely political (Seedhouse, 2004). Therefore, it seems that hospital nurses in this study need to understand broader meanings of health promotion. That is, all the above evidence might propose that the information-giving approach and the fear of illnesses might not result in changing individuals' poor health practice. This highlights the limitations of health education as opposed to politically driven and empowering based health promotion (Whitehead, 2001, Ogden, et al 2002).

8.2.2 The Absence of Health Promotion Principles from Nurses' Encounters with Patients

Further analysis of both interactions and field notes lend validity to the conclusions about nurses' limited practice of health promotion as explored above. The analysis shows the degree of development of nurses' roles in health promotion from a wider perspective. Some issues have already been pointed out above (e.g. holism of health). The impact of the interaction was localised rather than systematic and often did not move beyond the hospital doors. Yet it is argued that the health care organisation is obligated to a radical reform of health service away from the individualistic and medically oriented service to a more empowering and a wide reaching community health service (WHO 1997, Whitehead, 2004a, 2005).

The interactions with patients and their families under the category of "limited health promotion practice" were lacking a focus on creating an environment conducive to health as well as recognition of the social and economic detriments to health. These findings are validated inductively and deductively by nurses' narrow descriptions of health promotion concept and their attitudes towards health itself as shown in chapter 6, (section 6.2) and chapter 7 (sections 7.7.3.1. 7.4.1). For instance, empowering patients, fostering self-esteem, negotiating care and integrating a health policy into care were largely absent from nurses' conceptualisations of health promotion (Tones and Green, 2004, Whitehead, 2005).

In line with this, internationally it was found that socio-political health promotion actions are largely neglected by nurses and predominately shaped by a medical and preventative method of health education activity (Casey, 2007, Kelly and Abraham, 2007). Whilst nursing and health promotion have at their core humanistic philosophy, the reality is that nurse's practice is shaped by the medical model (Whitehead, 2001).

Whilst the importance of the medical approach is valued, the former elements might interplay with the whole family's decisions. For example, health insurance does not cover all Jordanians and some might be unable to buy medicine and take it at home. Indeed, collaborative health promotion work was not only absent within the hospital, but also apparently within the local community. No evidence was found to indicate that nurses were engaged in communication, negotiation and partnership with other external health care centres and agencies to ensure the continuity of care and health gain after discharge time. Engagement with a lay group of people to identify their health needs and explore their beliefs did not form the nurses' practice during the encounter. It is not surprising that nurses' roles in delivering health promotion was not being realised in hospitals (Casey, 2007, Kelly and Abraham, 2007) and such roles have been questioned (Whitehead, 2003, Casey, 2007, Whitehead et al, 2008).

Finally, it is worth noting that the contribution made by patients to the interaction was limited. Their "hidden" agenda was not explored and their role often did not move beyond following the nurse's instructions. On this basis, it can be argued that patients were not encouraged to be armed with power and consequently able to make more informed decisions (Houston and Cowley, 2002, Tones and Green, 2004). Another point to be appended to the above is the marginalisation of cultural practices related to health. Exploring and clarifying them is essential for congruent cultural health promotion activities (Andrews and Boyle, 1999). In one incident, the researcher noted that the nurse did not pay a lot of attention when a patient from an outlying village asked her if he can keep taking "Sage" at home with the antibiotic. The nurse replied that "you need to take only the antibiotic". Whilst it is

acknowledged that combining home remedies and antibiotics might have negative outcomes, her role in health promotion would have been more developed if health cultural practices were further explored. Given that the health care system is a cultural system, the aim should be that the dichotomy should not exist between lay knowledge and professional knowledge (Kim-Godwin et al, 2001 McLennan, and Khavarpour, 2004). A further point needs to be attached to the above. Whilst the absence of health promotion principles from nurses' encounters with patients might have a negative impact on nurses' health promotion work, the situation could also contribute to poor clinical placements for nursing students. It is argued that within the clinical learning there is a shortage of new role models in health promotion as the majority of nurses adhere to infective and a biased disease centred model of health promotion (Smith et al, 1995) and a limited integration of theory and practice of health promotion (Smith et al, 1999, Cross, 2005). It can be argued therefore that the absence of health promotion principles from nurses' encounters with patients might not only compromise patients' health needs but also contribute to unsuitable clinical placements for nursing students.

8.3 The Advanced Practice of Health Promotion

Whilst evidence from the above findings indicate that nurses' roles in health promotion are narrowly developed, the inductively derived analysis shows a brighter picture of practice. Some of those key principles of health promotion and health education skills were integrated in the interaction with patients. Guided by the framework of analysis (See Chapter 4), deductive analysis reveals that nurses' practices in health promotion operate at two levels. Whilst the first focuses on individuals' needs, the second concerned the structural determinants of health.

Therefore, unlike the "limited health promotion practice", advanced practice captures both the comprehensiveness and complexity involved in health promotional work. On this basis, there are multiple roles to play and various inter-connected issues to contemplate. Whilst it is promising, examples of advanced practice of health promotion were a minority. In fact, this can be represented only in 4 (20%) discharge

interventions and 6 (30%) medical rounds. Out of four encounters carried out by diabetic nurses, three can also be addressed under this category. The advanced health promotion practice is presented in three contextually different encounters as follows:

Box 3 : The encounter between the medical nurse and her patient (discharge time)

“The nurse entered the room of a patient who was to be discharged. It seems that a good trust and therapeutic relationship had developed between them as evidenced by the warm welcome given by the patient and her family”.

N- I do not want you to go home and leave us! (Smiling)

P and her family- (laughing)- really we had very nice time in this ward. Nursing staff are very nice

N- Good. I got your discharge letter and will get in touch with your consultant as well as respiratory therapists to see about your future follow up. Overall, I think you did improve a lot in comparison with the last time you were admitted here. This leaflet is about the health of your respiratory system. You can keep it and discuss it with your family members. Any questions (directed to the whole family)

P- Thanks a lot.

N- These tablets need to be taken at home as prescribed (the nurse showed her and her family the tablets, colour, functions, side effects). The family was involved during this encounter and asked questions.

N- You told me before that you live in a ground floor, your son is here now to hear that you need good ventilation and no dampness!! (All laughing). This could have a very bad impact on your breathing. As you have a chronic respiratory problem, taking the medicine alone is not enough. You need to have a good environment.

P and her son - already we are going to fix up the windows and the floor.

N- sounds good.

(Recorded discharge intervention on medical ward)

Unlike the limited health promotion practice outlined earlier in this chapter, the nurse has moved beyond information-giving and medically oriented interactions.

Evidence demonstrates that social and environmental determinants of health were incorporated into the agenda of the encounter. Whilst the example is simple, it illuminates the complexity of health promotion work as it shows the link between poor housing and health. Although the time for the encounter was limited, it was used as an opportunity to discuss different issues at the same time.

Field notes accompanied by observation indicate that the nurse was skilful in terms of good verbal and non-verbal communication as evidenced by the established relationship of trust with the whole family. This might facilitate the utilisation of a two-way collaborative and negotiating approach during the interaction and therefore enable the principles of health promotion to be translated into practice (e.g. empowerment and partnership). However, the empowering approach in the above context not only fosters self-efficacy and self-esteem but also neutralises the power between nurses and patients (McQueen, 2000, Canter, 2001). This involves an active learning process that informs the nurses' action plan (e.g. learning from patient about poor housing and its impact on health).

Although no evidence was found to suggest that there were contacts with the local community for a future follow up, it seems that multi-disciplinary teamwork within the hospital was a feature of the interaction (the nurse + consultant + respiratory therapists). As the background of that nurse was examined, no key differences in comparison with her other counterparts were found (e.g. the level of education, the length of experience). Nevertheless, at the time of data collection, it was noted that some nurses call medical patients "residents" and "experts" due to the length of their hospitalisation. On this basis, it might be possible that medical nurses are more exposed to patients' socio-economic problems as well as their family issues. This could broaden nurses' understanding of the complexity of both health and health promotion (Davis, 1995, Maidwell, 1996). These findings are consistent with the questionnaire evidence suggesting that, unlike surgical nurses, medical nurses are less likely to agree with the definition of health as the status of absence of illness. This theme is to be revisited in the Discussion Chapter. In another interesting

encounter with a patient from Yemen other issues of significance to the development of nurses' roles in health promotion were uncovered. See the following box.

Box (4) The encounter between the nurse and patient during the medicine round

“The nurse is about to give anti-hypertensive medicine to the patient. His family were sitting around the bed and the curtains were closed to somewhat isolate themselves from other patients in the room. The whole family came recently from Yemen and seemingly had not yet adapted to the new environment and, presumably, culture”

N- Hi Mr X, how are you today? Seems you have a nice time with your family.

P- Thanks I am ok. Do you want to have a cup of Yemen coffee?

N- Yes please I will have it after you take your medicine. This is the tablet for your blood pressure. You need to take it now three times a day.

P: I was in Yemen having different herbs prescribed by the best local healer. I feel ok, I do not want it.

N- Do you have a sample of these herbs.

The family gave the nurse a small bag containing different herbs and a blue cubed stone “Talisman”

N- Do you mind if we get in touch with the pharmacology department to check them and give us advice? Some are specialised in herbs.

P- Ok, but I need them back later, they are costly.

N- No problem, one more question please, what is this blue stone in the bag?

The patient and his family: we carry this talisman when we travel, so it keeps us safe and protects us from ill wishers. Is it ok to put it under the pillow before bedtime? It prevents bad dreams.

N- Of course it is ok, I will tell the other carers about this so they will be aware of it when they change the sheets in the morning.

“The patient and his family felt happy and as a result the patient decided to take the new medicine”.

A key theme to emerge from this encounter is the cultural care and effective communication approach. Whilst the intention is illumination rather than generalisation, the evidence highlights two aspects of nurses' development of health promotion practice. Firstly, cultural beliefs and practices were explored and respected during the encounter despite possible conflict with the nurse's own beliefs. It is worth noting that the nurse was sensitive to the cultural lifestyle linked to certain values. More specifically, the encounter involves cultural skills (e.g. the ability to examine cultural health needs) and the awareness of cultural behaviour of a certain group of people (Smaje, 1995, Kim-Godwin, et al 2001). Secondly, the patient's initial decision not to take medicine due to personal beliefs was respected. This might have given him some autonomy and thus fostered self-confidence as explained in the empowerment model for health promotion (Brown and Piper, 1995, Houston and Cowley, 2002).

On this basis, it can be argued that the nurse has successfully incorporated aspects of patients' own interpretations of health in their care plans (e.g. allowing the patient to use a "Talisman" to prevent bad dreams and ill wishers). As shown by the encounter and confirmed by previous studies (Young, 1996, Lee and Newberg, 2005), doing so would result in increasing patients' satisfaction about health care being delivered to them as well as motivating them to use the available health care services. That is, an empowering encounter led by a partnership and dialogue approach as opposed to an expert led and authoritative communication approach is a prerequisite for establishing culturally competent health promotion activities.

Moreover, it seems that the nurse was cognisant of the complexity of the health care system as a cultural system. This is evident by narrowing the gap between the professional knowledge based on scientific evidence and lay knowledge based on cultural beliefs and norms. It should be noted that health services could be perceived negatively by people when they fail to fit with their way of life, needs and cultural expectations (Leininger, 1995, Kim-Godwin et al, 2001). It is therefore not surprising

that the well-planned health care could make no difference to people's health when it disputes their internal understanding of the cultural meaning of health (McLennan and Khavarpour 2004). This might explain patients' dissatisfaction about how their needs of health are met narrowly by nurses as explained in chapter 7, section 7.5.2.

Placing the encounter within the context of health promotion approaches, it seems that different approaches were utilised. These were, the medical approach (anti-hypertensive medicine and the medical problem itself) and socio-cultural approach exemplified by the exploration of cultural practices. Although no complex and costly interventions were used, health might be promoted through the consideration of cultural beliefs and working with them rather than against them (Van Leeuwen and Cusveller, 2004). Therefore, taking into account the cultural meaning of health would not only enhance the communication between nurses and their patients but also it maximizes the efficiency of the health care being delivered including health promotion.

A further encounter between a patient and diabetic nurse offers further evidence about the extent to which health promotion is featured in the practice of nurses. As the interaction lasted around 30 minutes, it is presented briefly in the following box.

Box (5): The encounter between the diabetic nurse and patient

(The nurse prepared the patient file and asked other nurses about his background and medicine. This will be the first visit.)

N- Hi Mr. X. How are you today?

P- thanks. I am ok.

N- My name is Y and I am one of the diabetic nurses here at the hospital. I will work with you during your hospitalisation (detailed introduction) . She asked the patient if she can sit and talk with him.

P- that is great. I would be grateful if you can offer me with some advice about my problem.

N- Can you hear me from this distance?

P- Sorry I have problems with my left ear.

N- How about this (moved closer to the patient but without interfering with his privacy)

N- Are any of your family members here? I need them to join us.

P- Unfortunately, my daughter is at the university now and will visit me in the evening.

N- Ok, I would like you to tell me about your journey with the diabetes! (Smiling face).

P- I was diagnosed with diabetes about 10 years ago. Everything was ok but in recent years the sugar was so high and a big ulcer has developed on my right foot. I started taking lot of medicine but it seems that they do not work anymore.

N- Carry on please, I will examine your foot after talking with you.

P- I take insulin but the sugar level sometimes is high. I do not eat a lot of sugary stuff and I follow the medical instructions as they told me.

N- Could you tell me if you have any family or other problems at home? I know this is a personal question but I think sometimes that high sugar levels could be related to hidden factors.

P- I am overall ok but I am unemployed because of my illness. You know today's living costs are very high and not like before. We used to farm almost everything at home. We did not buy a lot of stuff from the market like today (Comparing life in seventies and now). I was working in a big factory as a production line supervisor and everything was ok. Then, I was diagnosed with diabetes and it destroyed my life. I got retired and the factory gives me now about 220 Jordan Dinar a month (about £170). I think a lot about how to manage my treatment, house rent and my daughter's university fees.

(Put his hand on his face as an expression of sadness).

N- I will check your health insurance and see if we can refer you to other agencies where you can get free and good treatment. Meanwhile I need you to be responsible for your health especially on how to give yourself insulin. Next time I will bring all the equipment needed and teach you with your daughter about how to calculate the dose and give it by yourself.

P- It sounds very good.

N- Where do you usually take insulin?

P- Upper arm and thigh.

N- Well you need to take it from now on in your tummy. Here or there (pointing her finger at his abdomen). Insulin absorption is better in abdominal muscles. May I see the little ulcer on you foot.

P- Ok, please do.

N- It is still small but if you do not give it a lot of attention it gets worse. You need to bring a mirror next time and so you monitor the improvement or deterioration by yourself.

P- Ok, so when you going to visit me next time

N- Tomorrow- I need to get in touch with nursing staff, your doctor and the nutritionist, so we can deliver you the best care.

P-That is great-thanks

In addition to the collaboration and participation, other elements integrated in the spirit of a more advanced health promotion have also emerged. The contribution made by the patient was not confined by the one-way standardised approach. Effective communication and listening skills and adhering to the patient focus rather than a nursing focused agenda was the heart of the interaction.

There are two types of therapeutic interactions identified in the above encounter. The first is a personal interaction, and the second is a professional interaction which was therapeutic in many ways. The former has helped the patient to feel better psychologically by being a good listener and supporter, and the latter might resulted in improving the physical health.

In the personal interaction, it seems that the patient has experienced the humanistic and egalitarian relationship which existed with the nurse, exemplified by offering assurance and support for the whole family. This type of relationship is the core of new nursing (Ersser, 1998) and as a health promoting approach that enhances socio-

psychological health (Richardson, 2002). The health promoter in this context has a role focused on helping the individual to formulate his goals.

Thus, such an approach is characterized by two-way communication in which the educator seeks to promote independence of action related to negotiated outcome (e.g. encouraging the patient to monitor the ulcer on her foot using a mirror). However, it should be noted that an empowering and non-authoritarian focus in the relationship between the educator and patient is utilized by few nurses. Findings in chapter 7 (Sections 7.4.1 and 7.6) showed that the majority of nurses' have emphasised the utilisation of an expert led communication approach when they attempt to promote patients' health.

An interesting finding to note is the shift from a medical focus (*diabetes*) to the consideration of more complex factors involved. The determinants of health were explored in a more holistic way in comparison with the "limited practice" outlined earlier. That is, no dichotomy exists between physical health, low income and family demands. On this basis, the nurse's health promotion work was a move away from an individualised responsibility and blame approach towards a wide reaching work encapsulating political and economic action (Tones and Green, 2004, Seedhouse, 2004).

In line with the movement of health promoting hospitals, the nurse attempted to establish communication channels with the local community and other agencies that could offer the needed help (WHO, 1997, Whitehead, 2005). Simply, she has multiple roles to play at the same time as carer, educator, advocator and communicator. The net result of such roles might empower patients and maximise health gain.

Nevertheless, no evidence was found to indicate that nurses were engaged in health policy formulation at a national level. The extent to which nurses are being involved in making decisions about improving patients' economic status is unclear. Therefore whilst some advanced development of nurses' role in health promotion is recognised, their health promotion work is not a fully planned move towards a wide

reaching work encapsulating political and economic action (Seedhouse, 2004). The former encounter suggests that nurses might be confronted with cases that are in need of both long-term economic help as well as medical treatment because of the absence of a practice operating at the level of policy, economy and regular activities which might be related to the lack of knowledge, nursing power or both. This will need further data from other methods especially those interviews with ward supervisors.

8.4 Summary of Hospital Nurses' Practice of Health Promotion

Evidence from observation and field notes might explain the prevalence of a traditional health promotion style over the more advanced one. Overall, the limited practice is consistent with the narrow perception of the meaning of both health and health promotion reported by many participants.

The activities carried out in the name of health promotion were inextricably linked to the way in which health promotion is practised by nurses. An example is offering health knowledge in an endeavour to change the behaviour and lifestyle of patients with no clear consideration of wider issues of what health promotion involves (e.g. participation and socioeconomic factors). However, these findings are further confirmed by previous international studies (Furber, 2000, Cross, 2005, Casey, 2007). That is, nurses' perceptions and practice of health promotion revolve around an orientation towards illness management through the utilisation of a one-way communication approach as opposed to the care embodied by a set of values such as empowerment, equity and strategy constructed from the ground up. Yet the chapter has shed light on some advanced development of nurses' role in health promotion encapsulating the above values.

The advanced practice could be as a result of a mixture of different factors. In addition to the length of patients' hospitalisation, the nature of the education nurses were exposed to needs to be taken into account.

Generally speaking diabetic nurses show better grasp of health promotion principles and skills than their counterparts. A close examination of their educational

background would suggest that they had a further degree in diabetes and its management. The curriculum involved had more focus on health promotion related issues than that of other nurses (this will be expanded later in one to one interviews). A further factor to keep in mind is related to the nature of cases hospitalised at the time of data collection. For example, diabetic patients are often suffering from multiple health problems and they may be more aware of the health care system than others due to the recurrent admissions. This might give diabetic nurses more opportunities to establish relationships and explore needs. These findings add validity to the conclusion suggesting that diabetic nurses had a better developed role in health promotion than their counterparts, as pointed out by the manager of training and development (See Chapter, 7 section, 7.7).

As the current researcher spent significant time in the hospital, field notes suggest that diabetic nurses were well armed by self-confidence and power in comparison to their counterparts. In one incident observed, a diabetic nurse reported a doctor to the department because of lack of co-operation and vague prescriptions. It was found that such nurses were guided and managed by the national centre for diabetes. The centre is managed by high profile consultants who won national and international awards for their excellent achievement in diabetic care. They offer diabetic nurses advanced training (e.g. research methods, communication skills, teaching and leadership). According to diabetic nurses, the consultants of the centre support them and, for example, offer them advanced courses in other countries. This context for professional working is very different from the situation of surgical and medical nurses who are managed by nursing. This is to be illuminated in chapter 10 of this thesis.

In contrast, during an informal conversation in the coffee room, it was found that nurses in surgical wards have less power and thus autonomy. A senior nurse reported that in one case she complained about a doctor as she did not show respect to the nurses during communication. The nursing supervisor only resolved the complaint by saying that “you know, that is her personality” and the nurse felt frustrated. Such examples introduce much more sophisticated factors related to the development of

nurses' roles in health promotion, factors perhaps generated by the nature of organisational structure as well as management. The discussion encapsulated this theme is revisited later in this thesis.

To sum up, the analysis of both observation and field notes show that nurses' actual practice in health promotion was poorly developed and narrowly guided by the individual approach. It is often traditionally rooted in the ideology of health education as opposed to the recent paradigm of health promotion operating at wider levels (Tones and Green, 2004, Seedhouse, 2004).

However, many interactions and perceptions of health promotion lacked more advanced principles of health promotion such as collaboration, lay group participation and clarifying values and beliefs of certain groups of individuals. On this basis, nurses' role in health promotion can be located within the framework of health education as opposed to health promotion. However, the theoretical ground of this thesis argues that health education alone is ineffective, ethically questioned and fails to address wider issues pertinent to health (Piper and Brown, 1998, Tones, 2001, Casey, 1997). The reality is that the aim of health promotion is widely political (Seedhouse, 2004) and thus health education needs to be carried out within a supportive political environment.

However, even operating at the health education level might be questioned. For example, due to the implementation of an expert nurse led approach, it is difficult to examine the extent to which health advice was understood by patients and will be adhered to. That is, the overall activities carried out in the spirit of health promotion are limited and ethically questioned due to the lack of recognition of structural factors interfering with individuals' decisions. Therefore, it seems that hospital nurses in this study need to understand broader meanings of health promotion in order to maximise patients' health gain and thus foster their self-actualisation (Maslow, 1976).

Nevertheless, promisingly, the limited health promotion practice was balanced by evidence highlighting the development of a more advanced practice. That is, a practice driven by the current spirit of health promotion encapsulating both individuality as well as structural determinants of health.

8.4.1 The Congruence Between Nurses' Perception and Practice

The gap between perceptions and practice is a largely unexplored area in health promotion literature due to the nature of methods used (McBride, 1994, Cross, 2005, Whitehaed et al, 2008). In addition to the discussions and debate about nurses' encounters with patients and their perceptions of and attitudes towards health promotion, this analysis reveals different dimensions of relevance.

Whilst the link between perceptions and practice is complex and multifaceted, it could be explained empirically in two distinct but interconnected ways. First, it seems that perceptions held by nurses and their knowledge could shape the practice and the overall philosophy of health promotion. Conversely, this practice in turn could contribute to the construction of nurses' perceptions and enable them to gain more skills in health promotion. These two way influencing directions are explained below within possible limiting elements.

In terms of theory and practice hospital nurses' made little development in health promotion as evident by the lack of key health promotion principles and values in their theoretical perceptions and actual practice. The limited understating of health and health promotion might play an instrumental role in determining or influencing the way in which health promotion is operationalised into the framework of practice. However, It is argued that health professionals are unable to theoretically define and delineate exactly what constitutes health promotion and health education as their effectiveness depends on sound theory (Paley, 1996, MacDonald, 2000, Casey, 2007, Whitehead et al, 2008).

Related to this, findings from the questionnaire and FGDs with nurses indicate that health and health promotion revolved around physical treatment and medical markers. Likewise, medical nurses' perceptions of social and psychological health were found to be an integrated element of their interactions with patients.

Yet, like previous studies (McBride, 1995, Cross, 2005, Casey, 2007), the majority of hospital nurses in general hold a micro-role of health promotion which is lacking a firm theoretical background and rooted in a simplistic health education ideology and related socio-cognitive theories. Such a role tends to focus on delivering individual-to-individual health education activities that could prevent disease and complications but does not consider the socio-economic levels at which health promotion operates (WHO, 1997, Casey, 2007, Kelly and Abraham, 2007). This contradicts the argument that health education and related economic and environmental support for behaviour conducive to health needs to be integrated into the process (Stuifbergen, et al 2000, Resnick, 2003). That is, the role of hospital nurses in health promotion is complex and multi-dimensional. It involves providing health information, promoting self-esteem by empowering individuals, encouraging decision making and changing physical and social relations.

Whilst the Hawthorne effect cannot be completely ruled out (e.g showing more attention given to health promotion), nurses' experiences of health promotion were largely congruent with observational evidence (confirmative triangulation). The micro-role in health promotion was validated by their perceptions and the content of encounters with patients. As nurses lacked knowledge in health promotion, it might be difficult to modify their behaviour at the time of observation. The busy wards and the significant time spent at the ward might be a contributing factor to the emergence of congruency between theory and practice. Under time pressure, nurses, especially in surgical wards, could be more concerned about how to get nursing tasks done instead of idealising their practice as a result of observation.

As the observation was carried out after the FGDs with nurses, they might become familiar to the researcher and thus they could have paid less attention to his presence.

Given the fact that the researcher was not part of the hospital management and nurses were assured about the confidentiality of this research, the impact of the Hawthorne threat on the credibility of data was kept to a minimum.

In view of the above analysis, it can be argued that nurses' perception might influence or structure the practice. Thus, logically one can postulate that unless nurses have positive and complex perceptions of health promotion and related knowledge, their capability to actually promote the health of a patient is in vain. It is not surprising therefore that socio-political health promotion work is absent from hospital nurses' practice due to the lack of theoretical clarity of its principles (Casey, 2007, Kelly and Abraham, 2007). On this basis, it seems that moving away from a limited medical model of disease prevention to health promotion towards politically orientated health promotion actions needs a firm theoretical ground (Liimatainen et al, 2001).

Although evidence to support such a postulation is available (see above), it should be taken with caution. Whilst the overall evidence shows that nurses' perceptions of health promotion are limited, some health education activities reported were absent from the practice. For example, some interactions were very short and no health education messages were given (e.g. side-effects of medications).

Indeed, participation was not associated with patients' education. Likewise, it seems that care is carried out in a fragmented way, lacking collaboration amongst health professionals. Yet health education alone is ineffective, ethically questioned and fails to address wider issues pertinent to health (Piper and Brown, 1998, Tones, 2001, Casey, 2007). Thus, whilst nurses' perceptions were largely congruent with the practice, there are few exceptions worth consideration. However, all evidence shows that nurses' perceptions and practice were largely congruent in this analysis. Like other authors (Paley, 1996, MacDonald, 2000, Casey, 2007, Whitehead et al, 2008), it is argued here therefore that nurses' perceptions of health and health promotion might basically shape the actual practice.

Secondly, the congruence between nurses' perceptions and practice might be explained in a reverse way. That is, the practice might influence the perception in the absence of theoretical knowledge about health and health promotion. The meanings attributed to health promotion and health expressed by nurses were consistent with the overall nature of practice on the ward level. Some nurses pointed out that their understanding of health and health promotion were "picked up" by their experience.

Interestingly, no significant differences were found between junior nurses and senior nurses in terms of perceptions and practice. This was surprising as the nurse educator reported that nursing graduates are trained as health promoters. Thus, it was expected that junior nurses could have more comprehensive and complex responses about health promotion (at least in theory) than senior nurses. This however was not the case. The limited perceptions of health and health promotion of junior nurses might be determined by the ward routine practice and more specifically by what senior nurses do.

This explanation might confirm the argument that in the clinical learning environment there is a shortage of new role models in health promotion (Smith et al, 1995b, Schickler et al 2002) and thus a limited integration of theory and practice of health promotion principles such as empowerment and political actions (Smith et al, 1999, Cross, 2005). The extent to which the ward climate might shape nurses' perceptions needs to be considered. This is to be debated in the discussion chapter (e.g. hierarchical relationship among nurses).

It can be concluded that at the time of data collection, nurses were operating as health educators as opposed to health promoters. This conclusion sits comfortably with the international evidence indicating that nurses' roles in delivering health promotion was not being realised in hospitals (Casey, 2007, Kelly and Abraham, 2007) and their ability to implement effective health promotion activities have been questioned (Whitehead, 2003, Casey, 2007, Whitehead et al, 2008). The above conclusion however should be understood within the overall hospital nurses' working environment identified below and fully debated in the discussion chapter

Chapter Nine: The Suitability of Hospital for Health Promotion

9.1 Introduction

In this chapter the extent of the hospital as a suitable setting for health promotion is examined from different sets of data. The overall evidence will be debated within the context of the health promoting hospital movement outlined in chapter 3.

9.2 Hospital Nurses' Views towards the Suitability of Hospital for Health Promotion

Quantitatively it was found that 60%, (n=35) of nurses agree that a hospital setting is suitable for health promotion. However, when such an item was statistically correlated with the demographic data, findings were significant in relation to the level of education (Chi-square=4, P=.001). It was found that 81% (n=47) of BSc degree holders agree with the item compared to Diploma degree holders (n= 6, 10%). In Jordan, nurses with a BSc degree are better prepared in health promotion than those nurses with a diploma (Petro-Nustas et al, 2001). These findings therefore confirm that nurses' education might shape their understanding of health promotion based setting approach (Rush, 1997, McDonald, 1998). However, caution must be exercised against the above findings. The vast majority of respondents (85%, n=49) had BSc degrees in nursing. By contrast, only 15% (n=9) held a diploma. Thus, although the significant findings are illuminative, they are statistically threatened by the limited number of diploma holders in this study.

In general, other findings show confirmative, complementary and conflicting evidence. This is explained below. Hospital nurses in both groups (junior and senior) were divided in their agreement and disagreement as to whether a hospital itself is a suitable place for health promotion.. However, it was found that the suitability of the hospital for health promotion is associated with the availability of patients:

“..... [hospital]is very suitable for health promotion. You know you can find different patients’ suffering from the same health problem, so you meet a large group of patients” (surgical senior nurse3).

*“That is right, many patients in the ward have diabetic ulcers on their feet”
(Surgical senior nurse 4).*

Although such a theme is indicative of the suitability of the hospital for health promotion, it should be noted that it is underlined by the illness orientation. Related to this, no links were made about promoting the health of the overall community and viewing hospitals as centres for the development of public health policies.

Other participants have expressed their disagreement and suggest that:

*“.. the current atmosphere is not suitable for health promotion. This is due to the hospital management and the lack of patients’ receptivity to health promotion”
(surgical senior nurse4).*

“ I think that the environment is suitable for providing urgent medical care instead of health promotion” (medical senior nurse 2.

It would appear that judging the suitability of a hospital for health promotion is not free from overlapping issues. Its suitability depends not only on the overall working environment but also on the nature of patients themselves. The above extract offers a springboard to identify potential factors and might have an impact on the development of hospital nurses’ roles in health promotion.

These findings do not only offer evidence of how nurses perceive hospitals as a health promotion setting but also add further enlightenment as to how they understand health promotion. Labelling hospitals as only suitable for medical care suggests that health promotion is an added activity rather than an integrated element into the philosophy of general care. Yet, it was warned by Green et al, (2000) that the

hospital as a setting is beyond carrying out certain health related goals within the organization. Instead, it is “the medium and the product of human social interactions” (Green et al, 2000, p23).

On the basis of above extracts, it can be argued that there is a perceived dichotomy between health promotion and care being delivered to patients within the hospital setting. This might indicate further that those who did not agree with the suitability of hospitals for health promotion felt that it would add extra workload to the “medical care”. Indeed, all responses lacked reference to the link between the hospital as a health organisation and the local community. Nurses have exclusively focused on the limited meaning of “setting” itself. More specifically, the hospital was perceived as a physically localized health care system rather than a cultural system interplaying with the local community (Whitehead, 2005). Thus, according to nurses’ perceptions, the hospital does not act as an agent to use a community-based approach for health by networking with local and national governmental and non-governmental agencies (Aiello et al, 1996, Johnson and Baum, 2001). It is not surprising therefore that hospital nurses’ role in health promotion operates at individualised and educational levels and thus the suitability of hospitals for health promotion is marginalised (McBride, 2004, Cross, 2005, Irvine, 2007).

As was the case with hospital nurses, ward supervisors expressed their agreement and disagreement about the suitability of hospital for health promotion. Whilst the surgical supervisor agrees that the hospital is a good place to promote patient health, the medical supervisor felt that outpatient clinics are better for that aim. This is the feature of extracts below:

“...hospital is good for health promotion. This could be carried out in the outpatients’ clinic. For example, they get health education leaflets about diabetes and hypertension. If they do health promotion in outpatient clinics, we will not have a lot of patients in this ward!!) (Surgical wards supervisor)

“ ...I think that outpatient clinics are more suitable than hospital. The hospital is stressful for patients and they feel they want to get the medical treatment, outpatient clinic could be better as they go there before being admitted to the ward. They [patients] can get health advice and leaflets [from the beginning]” (Medical ward supervisor)

During the discussion you could refer to the fact that transition / stress is often a time when people do change!

As outlined above, whilst the overall idea of health promotion within the hospital was welcomed, supervisors' views raise different issues. Firstly, in the light of the health promotion movement, no evidence was found to indicate that they were cognizant of its principles. Related to this, no one mentioned the hospital function as a health care system concerned with health policy formulation, creating an environment conducive to health and addressing health needs to society (Groene and Garcia-Barbero, 2005).

The way in which the hospital can serve the less privileged groups of people (e.g. homeless, refugees) was not recognized by ward supervisors. That is, the hospital was seen as a centre for ill people as opposed to an enhancing health gain setting encapsulating the ideology of health promoting hospitals (Whitehead, 2005).

The lack of recognition of wider functions of hospitals might be once again related to the way in which the term health promotion was perceived. As supervisors focused only on health advice and leaflets as health promotion activities, it is not surprising to consider the hospital as a centre for ill people.

Secondly, it is worth noting that there is a conflict between the needs of hospital patients as reported by them and how ward supervisors predict such needs. Whilst patients recognize the importance of medical treatment, some of them were more concerned about financial, social and psychological issues. Thus, the extent to which nurses' interventions are congruent with patients' systematic needs is open to debate. This is an important issue as there is a need to establish health promotion activities

matching the needs of patients. This is because offering congruent health care could decrease the fear of health services, maximise the respect between patients and nurses and enhance the overall community's well-being (McLennan, and Khavarpour, 2004).

Unlike hospital nurses and their supervisors, all patients expressed their agreement and positive attitudes towards hospitals as a health promoting setting. This reflected in the following extracts:

“Hospital is a very good place for health promotion. You see different patients suffering from the same health problem and you learn from each other” (Medical male patient 2)

“That is right.... here you meet doctors, nurses and physiotherapists. So you can take different health advice from the qualified people” (medical male patient 3)

Interestingly, the above findings are in line with the majority of nurses' attitudes towards the suitability of a hospital as a health promotion setting. Whilst it is recognized that a large group of the community can be approached at the hospital, it seems that the primary goal is to receive medical treatment. Bearing the current development of hospital roles in mind, responses lacked a recognition of its diverse functions within the society.

Related to this, no reference was made to the role of hospitals in establishing health policies and advocating the less privileged groups in the society. Environmentally speaking, hospitals produce a large amount of hazardous clinical waste and dealing with it by health promotion interventions might contribute to a safe environment conducive for health (Groene and Garcia-Barbero, 2005). Taking these findings together, it can be argued that building a supportive hospital environment conducive to health, with links to the local community, were missing from nurses' perceptions of the suitability of the hospital as a health promoting setting.

Whilst the lack of knowledge might be a contributing factor to the limited understanding of the setting approach to health promotion, there is a further point

worth consideration. It is possible that perceiving the hospital as a place for medical treatment is influenced by the organizational philosophy and nurses' framework of care. That is, an orientation to ill health as opposed to positive health, focusing on individual self actualization and considering structural dimensions of health (economical and political environment).

9.3 Summary of the Suitability of Hospital for Health Promotion

The overall evidence from this chapter indicates that the meaning of the setting for health promotion is not consistent with its wider meaning encapsulating the dynamic interaction between what goes on in the organisation and the local community (WHO, 1997, Groene and Garcia-Barbero, 2005).

Nevertheless, the idea of integrating health promotion within the hospital setting was welcomed by the majority of all participants (confirmative triangulation). Whilst quantitative data show the strength of agreement among all nurses, FGDs with nurses and patients dealt with the issue in greater depth (complementary triangulation). For example, the suitability of hospital for health promotion was rationalised by focusing on its role in offering medical care as well as a source of health knowledge. Nurses' perceptions of the hospital as a health promoting setting and consequences of their interactions with patients imply that the hospital was used purely to deliver medically oriented health activities. That is, nurses' earlier understanding and practice of health promotion are consistent with a limited function of the hospital itself as outlined in this chapter and confirmed by previous studies (Furber, 2000, Cross, 2005, Casey, 2007).

Consequently, the function of the hospital in the light of health promoting hospital movement was limited and revolves around dealing with already ill people. There is no wonder therefore that if nurses continue to perceive the hospital as an exclusive setting for medical care, they might fail to be motivated politically and thus will tend not to collaborate with other agencies to address societal and environmental factors pertinent to health (Whitehead, 2000, Seedhouse, 2004).

These findings might be a reflection to the lack of clarity about health and health promotion among nurses reported earlier. In other words, the hospital might be seen as a good place for carrying out health education activities exemplified by gathering health knowledge with patients through an individualised approach).

Whilst the medical function of the hospital is valued, evidence from FGDs with patients reveals that such a function does not always sit well with their expectations and needs. Related to this, some male patients were more desirous of a long term economic solution rather than medical treatment. Thus, some values inherent in the hospital role such as advocating on behalf of those less privileged people in the society (e.g. refugees) was not found in this analysis. That is, the function of the hospital in health promotion revolves around dealing with already ill people and operates at the micro-level as opposed to the macro-level encapsulating wider determinants of health and illness in the community (Aiello et al, 1996, Johnson and Baum, 2001 Whitehead, 2005)

However, as the study has a nursing focus, the diverse findings were specifically examined against the Vienna's recommendations (WHO, 1997) for effective health promoting hospitals (HPH). The recommendations were slightly modified to meet the current study questions. These recommendations were turned into questions and then targeted by the evidence outlined in previous chapters.

Table (6): The Suitability of the Jordanian Hospital for Health Promotion in Light of Vienna Recommendations (WHO, 1997) for Health Promoting Hospitals.

<p>Q1 Do nurses offer a holistic focus on health activities that improve patients' overall health status and not only focusing on physical health? The overall evidence shows that the holistic view of health was largely absent from nurses' perceptions and practice. Diabetic nurses appeared to have a better understanding of health than other nurses. However, the number of such nurses is in the minority (n=4-5) in comparison with nurses on wards (n=105). Thus, the first criterion for HPH was poorly met by nurses.</p> <p>Q2 Are patients' socio and economic factors considered when general care is planned and provided? As the view of health was limited among nurses, its determinant was often not systematically identified and incorporated into the framework of care. Although some patients had economic problems with health insurance, nurses focused only on medical treatment. On this basis, unsurprisingly, the second criterion was not clearly met.</p> <p>3 Are nurses able to establish communication channels outside the hospital (e.g. with other organisations) to meet certain patients' health needs? The overall evidence shows that nurses' perceptions and practice are interconnected and operating at the ward level. A few nurses attempted to move beyond that and communicate with external agencies in order to meet patients' needs (e.g. health insurance problem). Nevertheless, this has not shaped the perceptions and practice of the majority of nurses in this study. As a result, the third criterion was not fulfilled.</p> <p>4 Do nurses have a potential to affect health policy (e.g. banning smoking in the hospital and public areas.) The overall evidence indicates that nurses' capability to make decisions at the policy level is limited. There is some evidence to suggest that they might play a role in establishing preventive measures (e.g infection control) within the hospital. However, such policies are not inclusive to the population outside the hospital environment. No evidence was found to demonstrate that patients and their visitors were co-producers of such policies which could increase their compliance. Plausibly therefore, it can be argued that the above criterion was missing in this analysis.</p>
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Looking at above findings together, it seems that health promotion activities carried out by nurses are insufficiently contributing to the HPH idea. This brings about the question of how hospital nurses initiate and develop health promotion policy.

Simply, how far is it feasible for Jordanian hospital nurses to adjust their role in order to integrate health promotion principles into the framework of care. These questions raise the importance of the radical reform within the health organization from a curative service towards a health promotion vision. This shapes the heart of the discussion chapter in which strategies to achieve that are proposed and debated. However, it might be useful first to identify those contributing factors to the development of hospital nurses' roles in health promotion.

Chapter Ten: Factors Affecting the Development of Hospital Nurses' Roles in Promoting Patients' Health

10.1 Introduction

Findings that affect hospital nurses' role in health promotion are systematically reported in this chapter. Whilst the questionnaire offers an overall deductive picture about such factors, other methods deal with this theme in a more in-depth way.

10.2 Factors that affect Hospital nurses' role in health promotion from the questionnaire

Lack of time has been frequently documented as a key barrier to developing hospital nurses' roles in health promotion (McBride, 1994, Furber, 2000, Cross, 2005, Irvine, 2007). In the current findings, it was found that more than half of respondents (73%, n=42, mean= 4) agree or strongly agree with the impact of such a barrier. The mean score of 3.2 indicates a mild disagreement with the item reporting that respondents had received good education in health promotion.

The overwhelming majority of respondents were not satisfied with the current nursing leadership. In fact, two-thirds of respondents (62%, n=36) agree or strongly agree with the item suggesting that nursing leadership is dominated by doctors. Such findings are discussed in the following chapters in more depth. More than two-thirds of respondents (72%, n=42) expressed their agreement and strong agreement regarding patients' reluctance to receive health promotion delivered by hospital nurses. Finally, respondents were asked to express their agreement or otherwise about an item suggesting that "it is not possible to promote the health of the opposite sex". The vast majority of respondents (76%, n= 44) disagree and strongly disagree with the item (See table 7).

Table (7): Factors which could Affect the Development of Nurses' Health Promotion Role in Hospital.

Items	Strongly Agree	Agree	Cannot decide	Disagree	Strongly Disagree	Total	The mean scores
I do not carry out health promotion because of lack of time	45%,n=26	28%,n=16	10%,n=6	17%,n=10		58	4
I received good education in health promotion	19%,n=11	26%,n=15	16%,n=9	31%,n=18	9%,n=5	58	3.2
Nursing leadership in the hospital is dominated by doctors.	17%,n=10	45%,n=26	10%,n=6	16%,n=9	12%,n=7	58	3.4
Patients do not accept nurses to promote their health	19%,n=11	53%,n=31	5%,n=3	17%,n=10	5%,n=3	58	3.6
It is not possible to promote the health of opposite sex	14%,n=8	7%,n=4	3%,n=2	28%,n=16	48%,n=28	58	2.1

The potential factors that could affect the development of nurses' health promotion roles were correlated with respondents' demographic variables. Significant correlation was found between the workplace of respondents and the item "Nursing leadership in hospital is dominated by doctors" (Chi square=10, $p=0.031$). Two-thirds of respondents who work in the medical ward (62%, $n=36$) agreed more strongly with the item than their counterparts in surgical wards (48%, $n=28$). Again, this might be explained by the nature of medical cases which tend to be more chronic and frequently admitted to the hospital. On this basis, the possibility that nursing leadership on medical wards is more confident and thus autonomous in making independent nursing decisions cannot be ruled out. In line with this possibility, it should be noted that unlike surgical nurses, medical nurses in the focus group discussions were less concerned about the nursing blaming culture at the ward level. However, due to unequal numbers of respondents in both groups, these findings should be considered with care.

Further correlation analysis reveals significant findings between the item "I do not carry out health promotion due to the lack of time" and the place of work (Chi-square=8, $P=.046$). Surgical nurses agree more strongly with the item (60%, $n=12$) compared to medical nurses (37%, $n=14$). This might be due to the acute cases that need immediate medical actions to save lives and prevent disability (Davis, 1995). On the other hand, due to the length of hospitalisation of patients on medical wards, nurses might have more contacts with patients and thus opportunity to deliver at least health education.

Finally, statistical significance was found between the sex of respondents and the item "I feel that it is not possible to promote the health of the opposite sex (chi-square=10, $P=.005$). Female nurses tended to disagree more strongly with the item (63%, $n=12$) than male nurses (22%, $n=3$). It should be noted that the item reflects two questions. The first is whether male and female opinions differ? The second is whether it is inherently more or less difficult for male nurses to promote the health of female patients and vice versa? However, the reason behind the above significant finding could lie in the way in which nurses are allocated to work with patients on

wards. With the exception of emergency departments and intensive care units, observations found that male nurses work only with male patients in surgical and medical wards.

By contrast, female nurses work with both genders. Whilst such a nursing care system could not be used in other countries, respecting patients' cultural norms is essential for delivering a high quality of care (Higgins and Learn, 1999, Kim-Godwin et al, 2001 McLennan and Khavarpour 2004). Linking the above findings with the nursing care system, it would appear that female nurses are more familiar and confident in approaching male patients about health promotion. That is, although the vast majority of respondents (76%, n= 44) disagree with the above item, a close examination of data proposes that male nurses could find it difficult to promote the health of female patients. Whilst the dominance of female respondents in this study is acknowledged (60%,n=35), further attention needs to be given to this issue.

To summarise, the above quantitative evidence indicates that the lack of time, ineffective nursing leadership, as well as patients' reluctance to accept nurses' roles in health promotion, are barriers to the development of such a role. The findings however offer no adequate explanations of reported factors. Related to this, it was essential to examine the extent to which nursing leadership is prevailed upon by doctors and thus there is a need for much more complex responses from other methods. All factors have been categorised into two groups:- factors at the ward level and factors within the organisation and the Jordanian community.

10.3 Factors affecting the Development of Nurses' Roles in Health Promotion at the Ward Level:

The analysis has shown that the barriers which could affect the development of nurses' roles in health promotion are vast. Whilst this section attempts to highlight the potential barriers at the ward level, it also adds further empirical weight to nurses' understanding of health promotion and what is perceived to be done in its name.

10.3.1- The Lack of Time/Nursing Staff

Approximately all participants cited lack of time of nursing staff as a barrier for carrying out health promotion activities. In fact, lack of time emerged in discussions automatically before participants were asked to respond to the question. This might indicate the impact of such a barrier on their role in health promotion. The extracts below are typical of this:

“It is not possible to focus on different aspects of health in surgical wards because of busy shifts and lack of time. The number of patients is indeed a [barrier]” (surgical senior nurse 5”

Another participant expressed her agreement and goes on to add that

“..... I have 19 diabetic patients with infected feet plus 6 patients who need to be prepared for the operation room. I work almost alone as other staff are completely new and, eventually, I am the only one to blame if something goes wrong”. (surgical senior nurse 6)

Similarly, it was found that that lack of time, the shortage of nursing staff and the nursing care plan are inter-related.

“In addition to the lack of time to promote patients’ health such as educating patients about the risk of smoking, the shortage of staff is a problem” (surgical junior nurse 4)

“we do not have time as the focus is to get the nursing care done!” (surgical Junior nurse 3)

Such factors have been identified by medical nurses as well:

“I have 29 patients and many of them on IV therapy. If you want to educate them; you would not be able to deliver the primary care” (medical senior nurse 2)

“Yes we are not saying that we have no role in health promotion. Currently we cannot do it - not enough time or staff” (medical senior nurse 3)

These factors are reflected in the following extracts from the interview with ward supervisors:

“ we recognize the importance of health promotion but have no time to do it... nurses have no time to sit with patients and talk with them... we’ve got many things to do” (surgical ward supervisor)

“...sometimes very few nurses need to look after about 60 patients in both wings....” (medical ward supervisor).

Although different inhibiting factors are outlined above, they evolve around the lack of time and the shortage of nursing staff. Interestingly, even the lack of time was linked as a barrier to the holistic understanding of health in its own right.

Observational data together with the background of surgical wards would suggest that the demands on nurses in such areas are indeed high. This could prevent them from translating their health promotion role into practice. Nevertheless, in light of the above data, there is the danger of taking this assumption as a full explanation.

A closer look at the extracts indicates that nurses perceive care and health promotion in a separate way - if they have time they do it, if not they do not. Such perceptions are against the ideology of health promotion stressing that its elements (e.g. holism, collaboration and empowerment) need to be incorporated into the overall philosophy of care, rather seeing it as an added activity and thus extra workload.

Further findings add further illumination as to how nurses understand health promotion. It would appear that an individualised one- way approach and the traditional role of health education are evident. That is, health information targeting

the medical problems without taking into account wider issues at which health promotion is believed to operate (e.g. political and socio-economic issues).

10.3.2- Patients' Willingness and Beliefs

A second inhibiting barrier was identified regarding the patient's role. Participants expressed their concerns about the lack of patients' willingness to be involved in nursing health promotional activities. This is reflected in the following extracts:

"Some patients are not willing to hear any thing about health. As a result I do not pay a lot of attention to [health promotion] as I have other patients to look after"(Senior surgical nurse3)

The difficulties inherent in communication with some patients were perceived as a problematic issue:

"Talking with the elderly is often difficult. Although you spend a lot of time communicating properly with them, you end up with negative outcomes such as rejecting the care plan". (Senior surgical nurse4)

Although responses are conflicting, the class of patients might affect the development of nurses' health promotion roles. This cited factor is represented in the following two extracts.

"in private hospitals, patients are often educated and willing to listen to what nurses say when it comes to health. This encourages you to arrange health promotional activities for them, for example, about diet and diabetes. (surgical Junior nurse 4).

The disagreement with the above opinion was disputed by another participant

" I do not agree with this, private patients could be problematic. They might express a lot of complaints!! They like to talk to doctors instead" (surgical junior nurse)

The above findings raise some issues of relevance. Firstly, what is perceived as a health promotion activity is not beyond simplistic health advice rooted in the medical model (e.g. diet and diabetes). Further, some difficulties that nurses might encounter when they communicate with patients might lie in their limited understanding of health promotion. The words “listening to nurses” might suggest that the interaction between them and their patients are informed by a one-way autocratic approach as opposed to the communication within the framework of collaboration, participation and empowerment.

Interestingly, whilst socio-economic issues were largely absent from nurses’ understanding of health promotion, they are linked to communication with certain individuals. On this basis, it could be argued that there is a dichotomy between health promotion and communication among nurses. A further inhibiting factor from the point of view of patients is related to cultural and religious beliefs. This is exemplified by the statement below:

“One day I looked after a diabetic patient. I talked to him about the link between diet and glucose level. He replied that we live only once and God takes and gives health. He refused the health advice and kept eating a lot of Kinaffeh!) (surgical Junior nurse 3)*

*Kinaffeh is a Jordanian sweet containing a lot of sugar and cheese.

Likewise, the power of God in affecting people’s health was also reported.

“Some patients believe that God heals you and you cannot change your fate, so you do not like to interfere with their beliefs”.(surgical junior nurse 2)

Similar evidence was offered by medical nurses:-

“ some of them [patients] do not want to listen to nurses’ advice. They prefer to get in touch with doctors”. (medical senior nurse 2)

*“You know you can take the horse to the water but you cannot make it drink”
(medical senior nurse3).*

These findings are indicative of a recognition that cultural and spiritual beliefs might interplay with people’s intention to accept or reject health advice. However, this dimension was largely absent from nurses’ understanding of both health and health promotion. In fact, it is presented here as a barrier instead of an issue to be considered in a cultural health care system (Kim-Godwin et al, 2000). Indeed, these findings are alarming as it seems that nurses might have the view that patients’ beliefs are against the ideology of culturally competent health promotion.. In brief, claims suggesting that patients’ beliefs might affect the development of nurses’ roles in health promotion possibly lie in nurses’ limited understanding of health and health promotion together with the utilisation of a nurse-led expert approach.

10.3.3 Lack of Knowledge in Health Promotion

The questionnaire reveals that about two third of nurses (62%, n=36) agree that they have received good education in the area of health promotion. However, as illuminated below, it seems that they were referring to health education which informs their perceptions and practice of health promotion. Complementary evidence from other methods examines how education might contribute to the above barrier.

The lack of knowledge in health promotion was reported by hospital nurses and ward supervisors as reflected in extracts below:

“we do not have good health promotion courses before graduation. Now such courses have become essential components of nursing curriculum” (surgical senior nurse 3)

“ that is right, we do not have special courses in health promotion and enough resources such as leaflets” (surgical senior nurse1)

Medical nurses have also expressed similar concerns:

“ we have no courses in health promotion in this hospital”(medical junior nurse 2)

“that is true - they focus on medical things such as CPR” (medical junior nurse 3)

The above evidence is confirmed by the ward supervisor:

“Some nurses worked for a long time here but their knowledge was not updated in health promotion and other aspects of care” (medical ward supervisor).

Although the nature of the knowledge that participants lack is vague, presumably it refers to their understanding of health promotion focusing mainly on giving health advice about lifestyle and health problems. This is reinforced by mentioning the lack of leaflets as a problem in developing their role in health promotion. Whilst health knowledge might promote health, referring to leaflets as a delivery method poses doubt about their effectiveness. No mention was made specifically about the lack of knowledge in empowering and fostering the self-esteem of patients. Likewise, no references were made to the lack of knowledge in wider issues such as creating an environment conducive to health and making decisions to promote the health of the local community. Indeed, the lack of proper communication skills was not expressed despite it being a factor worth consideration as pointed out earlier. Yet the above evidence highlights the need to understand nurses' theoretical input into health promotion before graduation and after qualification. These are highlighted below.

A systematic analysis of nursing curriculum was not the intention of the current researcher. Rather, the aim was to offer evidence about the theoretical input of nurses in health promotion before graduation and after qualification. The analysis of elicited responses from the interview with the nurse educator (See appendix 4) reveals that nursing students are required to undertake a course entitled “health promotion and health education” before qualification. The course is divided into two parts. The first involves communication theories in general. The second part deals with health education, its principles in different settings such as community and hospital.

Furthermore, learning theories and teaching methods are a component of this course. The aim of this course with relevant activities is summarized in the following box:

Box (6). The Aim of the Health Promotion Course for Undergraduate Students

“ the course aims to improve the health of individuals and the community as a whole. Nursing students are asked to complete a project about an interview with patients and accordingly they need to analyze the verbal and non verbal communication with them in the light of course content. Health education activities are concerned about health advice and information- giving. Those who complete this part successfully then need to sign up a contract with families within the Jordanian community such as Baqa refugees’ camp. Then they arrange home visits focusing on different issues such as diabetes. They do activities such as checking blood pressure, weight and other[medical markers]..as well as arranging insulin self-injection programs (Nurse educator)

The above findings point out that nursing students are exposed to important elements of health promotion. That is, communication and health education. Students are required to get in touch directly with those who are in need of health education activities within the community. This might broaden their experience and thus maximises the learning process. This course needs to be undertaken by second year students. The researcher also found that first year students are exposed to another course of relevance. It is referred to as “fundamental nursing 1”. It focuses on the meaning of health, cultural beliefs and the disease process. Nonetheless, the overall course of “health promotion and health education” is underlined by one theme, i.e. it is largely guided by the ideology of health education as opposed to health promotion. This is reinforced by the individuals’ health education activities exemplified by educational encounters and monitoring the normality of medical markers such as weight and sugar level. No evidence was found to suggest that attention was given to health policy formulation and creating an environment conducive to health at a national level. These elements were absent from the interview data and in the given syllabus. However, internationally it is argued that the individualistic health education ideology was found within the framework of nursing education which

prepares students as role models of healthy behaviours whilst structural factors are likely to be ignored (Whitehead, 2002). The wider political and economic aspects of this health promotion are often absent (Rush, 1997). On the basis of the international and current evidence, there is little wonder that patients might be blamed for not adhering to health promoting behaviour.

In this study, It is worth remembering, that nurses' perceptions and practice sit largely with the ideology of health education as opposed to health promotion. It can be argued therefore that nurses are educationally more prepared to be health educators rather than health promoters. It is not surprising that health education and health promotion need to be clearly integrated into the curriculum for students and nurse educators need to act as role models (Naidoo and Wills, 1998) and ensure the suitability of clinical placements for nursing students' learning needs (Smith et al, 1999).

The analysis of the interview with the manager of training and development at the hospital reveals similar themes. The aim of the training department largely revolves around arranging administrative and medical courses. This is confirmed by evidence from ward nurses (See above). The following extract illuminates the nature of such courses:

" ..We arrange orientation programs for new nurses. Courses in infection control are also offered. ...we arrange CPR courses and we [explain] the job description to nurses. Usually, nurses ask for courses such as CPR and ECG. They want such courses in order to work in Gulf countries. Such courses are valuable for their CVs" (the manager of training and development).

As outlined above, it appears that the hospital nurses are likely to be exposed to medical education and training after graduation. Whilst this is important in its own right, no mention was made of specifically addressing the need for improving nurses' role in health promotion. Although infection control can be seen as part of health promotion, no reference was made to other components such as health education,

empowerment and establishing health policies. These findings therefore lend validity to nurses' claims indicating the lack of educational activities in health promotion within the hospital setting. In the light of the health promoting hospital movement, it seems that the education and training were not re-orientated towards the ideology of health promotion based settings. The extent to which the hospital is involved in carrying out projects that could inform health policy, managing dangerous waste and creating an environment conducive to health at the community and national level is unclear.

Taking findings together, it can be argued that hospital nurses are more exposed to orientation towards the medical approach to health as opposed to positive health focusing on structural and political dimensions of health (Tones and Green 2001, Seedhouse, 2004).

10.3.4 Lack of Health Promotion Vision in Hospital Nurses' Job Descriptions, the Philosophy of Care and Health Policies

The limited development of nurses' role in health promotion might not only be influenced by the factors outlined above but also by the available documents on wards. This section presents findings from the review of three main documents. This includes: job description, the philosophy underpinning nursing service, health policies and procedures. Due to the extensive amount of files found, the review was narrowed down to address specific issues pertaining to study questions outlined in chapter 4. Additionally, at the time of data collection, the target documents were under update and development. Therefore, the review here is a reflection on what was available to nursing staff at the time of this research.

1- Job Description

Job descriptions of both registered nurses and ward supervisors were reviewed and divided into two categories. The first involves job summary and the second deals with responsibilities allocated to them. The review of job descriptions reveals that

what nurses are asked to carry out revolves around delivering care guided by the nursing process. This is exemplified by the quote below:

“ the functions of staff nurses is to assess, plan, implement and evaluate the care of all assigned patients..[you need] to manage supplies and equipment within the area of work and promote teamwork with physicians and personnel of other departments”

The job description of ward supervisors includes the above and:

“ ...evaluating patients care and ensuring the continuity of care with other shifts on a 24 hours basis”.

The above findings are indicative that the quality of care is delivered in a systematic way ranging from assessment to evaluation. It is also worth noting that nurses are urged to promote teamwork. Nevertheless, this element was largely absent from the encounters with patients during discharge interventions (See Chapter 8). Further, no evidence was found to indicate that the concepts of “environment” as well as “local community” were integrated into the content of job description.

It seems therefore that nurses are exclusively focusing on delivering health care, targeting exclusively patients within the hospital context. That is, it is largely lacking values and principles which might contribute to modern health promotion. This idea is supported by the further review of allocated responsibilities. It was found that out of 18 responsibilities assigned to staff nurses no specific reference was made either to health promotion or, to a lesser extent, health education. However, a close examination of documents reveals that some responsibilities might be indirectly linked to health promotion. This is encapsulated in the following extracts:

“Explain procedures and treatment to patient and family”(responsibility 8)

“ prepare and administer medications according to the hospital policies and procedures” (responsibility 12).

“Adhere to hospital policy concerning universal precautions and infection control...” (responsibility 17).

These responsibilities might be addressed under one component of health promotion, i.e. illness control and prevention. Other components were not explicitly referred to. For example, whilst a treatment plan needs to be explained to patients and their family, educating them was not mentioned when medications are given. Likewise, the responsibility of nurses is just to adhere to the hospital policy. Responsibilities give no indicators to propose that nurses are asked to play a decision-making role in policy formulation that could enhance health gain. Although the importance of infection control is recognized, the extent to which their responsibility encapsulates the idea of creating an environment conducive to health is unclear.

The review of 15 responsibilities for ward supervisors show similar elements. Whilst they are diverse, they revolve around administrative work. This includes: assessing the number of personnel needed to provide quality patient care, investigating unit related incidents and reports and preparing monthly reports. The review found no specific mention of health promotion and its constituents. Nevertheless, some might be intuitively related to health promotion. This is exemplified below:

*“Knowledge of patients educational resources and utilises as appropriate”
(responsibility 7)*

“prepare and forecast budgetary requirements for personnel, supplies and equipment” (responsibility 11).

“ develop, review, revise and implement policies and procedures for the unit as per hospital policy” (responsibility 15).

The above responsibilities could be seen as signals for the development of health education at the ward level. This includes directing efforts and resources towards educating patients. Interestingly, it seems that developing and revising health policies are the responsibility of ward supervisors and not staff nurses. This could be due to the lack of autonomy offered to them. In other wards, wider issues related to health

promotion could be restricted only to ward supervisors. This resonates with evidence from earlier chapters indicating the nurses' role in health promotion is largely informed by information-giving as opposed to policy formulation

2- The Philosophy of the Nursing Service

The philosophy underlining the nursing service at the hospital was largely informed by job description and vice versa. This is presented in the following table:

Box (7): The Philosophy Underlining Nursing Services At The Hospital.

“ nursing service is committed to provide excellent and professional holistic care through the nursing process to patients attending the [x] hospital..... Nursing is an accountable profession committed to continuing education for its members and is an ongoing quality assurance in order to maintain current professional standards and contribute to the theory and practice of nursing. All nurses need to use communication, clinical skills, interpersonal relationships, organisational and management skills as the foundation for providing nursing care through the nursing process”

The review of the philosophy shows that delivering holistic care is an essential element of the nursing process and, plausibly, health promotion. Further, it would appear that there are some commitments to training and education aimed at the maintenance of optimum level of care. In keeping with findings presented in earlier chapter 8, two issues might emerge. There is a gap between nurses' perceptions and practice of health promotion and what the philosophy of the nursing service states. Whilst encounters with patients were mainly dominated towards the physical aspect of health, the philosophy urges nurses to deliver holistic care encapsulating other aspects such as mental and psychological. Nevertheless, the philosophy lacks values and principles inherited in the new paradigm of health promotion and related movements such as health promoting hospitals. For example, no mention was made to empowerment, advocacy, health policy formulation and economic regulations. It is also not clear if hospital nurses' roles in society are restricted to a geographic area.

That is, functioning exclusively within the hospital context. In line with the ideology of health promoting hospitals, no reference was found to indicate that ward nurses have a role in creating an environment conducive to health at the national level. These gaps might have compromised nurses' roles in health promotion.

3 Health Policies and Procedures

Under this category it was found that the available documents refer to job descriptions and the philosophy of care. For example, venepuncture and wound dressings should only be done by registered nurses. This was commented on above as part of the nursing process cited in the job description. Health policies are concerned about medical procedures in a detailed way. This includes: catheterisation, the procedure of cardio-pulmonary resuscitation and infection control measures. Thus, the presentation of this category is beyond the scope of this study. Nevertheless, it can be addressed under one component of health promotion. That is, disease prevention and preventing medical complications.

All of the reviewed documentation is available on wards. Nurses are asked to be familiar with it as part of their orientation program and annual evaluations. Therefore, the extent to which these documents might affect the development of nurses' role in health promotion should not be undermined.

10.4 Factors Affecting the Development of Nurses' Roles in Health Promotion Within the Organisation and Community.

Given the definition of setting outlined in chapter 3 (section 3.6) it was decided not to separate the hospital from its surrounding community. That is, factors within the community might affect hospital nurses' within the organisation and vice versa (see below).

10.4.1 Unsupportive Climate for Health Promotion within the Hospital

The analysis revealed that the above broad inhibiting factor encapsulates diverse elements. Thus, it was decided to explore them together to allow the picture about the climate in which nurses work to emerge. The elements include: the lack of communication between hospital staff, the incompetent nursing leadership and lack of power, and the lack of hospital management support. These elements are the features of the following extracts

“ the lack of communication is a problem. Today I went to a patient to give him insulin. I found that his doctor did not bother to talk to him about the new changes to his health status and his medication. So the patient refused to take insulin” (surgical senior nurse 3).

“that is right they [doctors] do not talk a lot with their patients” (surgical senior nurse 2).

“Sometimes if you talk with patients about health issues, they keep asking doctors a lot of questions and [as a result] we could be blamed!”(surgical (senior nurse 5)

“Each consultant has quite different ways to treat patients and as nurses we felt confused” (surgical senior nurse 5).

It would appear that the problem with communication is not only between staff and patients but amongst medical staff themselves. This could explain the lack of recognition of important principles of health promotion such as collaboration, inter-sectional teamwork and establishing links with the local community and other health institutions. Thus, it can be argued that lack of communication is a chronic problem at both micro and macro levels.

Other participants uncovered issues relating to the way in which nursing leadership is carried out.

“ I want to say that if things go wrong, nursing supervisors tend to blame only nurses!” (surgical junior nurse 3)

“I wonder what supervisors on wards do! Just administrative work: no support or any planning for health promotion, they know only how to search for mistakes! (Laughing and looking at each other) ” (surgical senior nurse4.

One participant highlighted a problem among nurses:

“We as junior nurses were motivated to do at least health education at ward level but we did not receive support from the ward supervisor and senior colleagues. I felt they wanted us to follow their steps and focus only on medical care. (surgical junior nurse 1)

The nurse educator points out also two confirmative factors related to nursing leadership and communication skills:

“.... I was told by many graduated nurses that they had problems with nursing leadership. They focus on medical care and have no good communication with nursing staff. I think that the criteria of selecting ward supervisors should be changed and not only focus on the experience. I noted positive changes to this in recent years but [it is still the beginning]” (Nurse educator).

However, ward supervisors blamed unsupportive hospital policies and the weak nursing leadership:

“ .. it is not allowed to inform patients about their health problems especially threatening ones until you have permission from their doctors. So we offer health advice after the patient is informed by the doctor” (medical ward supervisor).

“Sometimes you could be blamed if you talk about possible complications with patients.. some consultants think that this makes them more worried..”(Surgical ward supervisor).

“ the problem which could most affect health promotion is the weak nursing leadership.. This makes our motivation to do any activities very low. For example, the nursing department arranges only medical courses such as CPR. No research at all...” (Surgical ward supervisor).

Such findings not only raise questions about the nature of communication skills in operation, but also offer signals about the potential vision of nursing leadership concerning health promotion. More specifically, findings are indicative that nurses themselves might not be empowered at work to empower patients in turn. The statements “searching for our mistakes” and “blaming us” raise hierarchical issues among nurses. Given their educational level, it was expected that those surgical nurses with a Master’s Degree (n=2) were likely to dominate leadership positions in the nursing hierarchy. However, this was not the case. According to one of them, having a postgraduate education does not often improve your status in the organisation. This situation is not consistent with evidence suggesting higher education is essential for effective leadership (Scott and Moye, 2002). This is to be returned to in the Discussion Chapter. Whilst the evidence shows that the nurses’ ability to promote health could be restricted by the doctors’ treatment doctrine, it is worth reporting here that document review (e.g job descriptions) did not support that. In this context, no mention was made as to whether or not nurses are allowed to communicate with patients regarding medically threatening health problems. It would appear therefore that sometimes certain issues could be discussed specifically in response to situational problems at ward level.

The findings highlight a possible problem with the multidisciplinary teamwork. It seems that the interaction with patients could be carried out in the absence of co-operation between different health professionals (e.g. nurses and consultant). This

might cause inconsistency in the content of the message given to patients. Likewise, it seems that there is a power imbalance between doctors and nurses which creates a blaming culture. Nevertheless, when ward supervisors were asked if doctors interfere with nursing leadership, the answer was no.

*“..... Just if they have complains, they report them to the nursing department”
(Surgical ward supervisor)*

The supervisor carries on commenting more on the nature of nursing leadership. These findings suggest that the problem with nursing leadership is beyond the ward level. Related to this, whilst nurses claim that ward supervisors are not supportive enough, now, ward supervisors direct these claims towards the overall nursing management including the manager of training and development. On this basis, it can be argued that the lack of power can affect the development of nurses' role in health promotion at different levels, that is, the ward and organisation level. This needs to be examined within the context of the social image of nursing and the power imbalance between doctors and nurses.

10.4. 2- The Negative Image of Nurses and the Power Imbalance between Nurses and Doctors.

The lack of autonomy as a sign of power appeared to be a contributing factor to the creation of a stressful environment for hospital nurses. The extracts below are typical of this:

“we have a problem about nursing itself; we are often seen as inferior to other professions in the hospital such as doctors. This makes you frustrated” (senior surgical nurse 6).

Whilst the nursing profession has developed dramatically in Jordan within the last decade, it seems that it is not yet well armed with power within the organisation..

This is confirmed further below. Whilst this was pointed out by one participant, the current researcher noted that all participants shook their heads as a sign of agreement.

“you know people in general think we are “Tamrjeh” who know limited or no acknowledge in health care. So how do you think they will give attention to your role in health promotion?. Last year I made an error in administering the medication. All doctors and the ward supervisor blamed me a lot and made me feel so bad..... so people do not appreciate you and no medical staff support you.... if doctors make a mistake you can do nothing as they are doctors!! ”. (Senior medical nurse 6).*

*Tamrjeh: This classic Arabic word refers to those aid workers in the sixties and seventies who lacked knowledge, skills and clear job descriptions. Some people make jokes about them in the Jordanian culture.

In line with this complementary evidence, the ward supervisor offers a brief historical background about the nursing social image in Jordan:-

“..Long time ago nursing in Jordan had a very bad image and we were often treated like [waiters]. Now its image has improved a lot but it is still not as good as other professions like doctors” (medical ward supervisor).

The above responses are very complex as they involve different but inter-related issues and it was decided to present them as they are. First, it appears that the negative status of nursing as a profession might have a profound effect on nurses' morale and willingness to promote health (see the above). That is, regardless of the level of hospital nurses' competency in health promotion, they might be treated as unskilled and educated workers. In other words, their role in health promotion might not be realised due to the low status of nursing's public image.

Whilst up until now it seemed that there was a power imbalance between nurses and patients, there now appears to be a power imbalance between doctors and nurses. The above statement “as they are doctors” carries two dimensions. That is, not only were

doctors recognised in social prestige but also in their powerful position in the organisation which might shape the overall working environment for hospital nurses. These themes are returned to in the Discussion Chapter. However, meanwhile, it is worth reporting that further evidence suggests that the problem is beyond the negative social image of nursing and the power imbalance between doctors and nurses. It has also a gender dimension. It was stated that:

“.. . the hospital itself does not pay significant attention to health promotion. We do not have good power as nurses, doctors are more supported than us, you know men do what they want!! ” (The manager of training and development).

As outlined above, the statement “*men do what they want*” might be a reflection of male dominance in the health organization. The interchangeable use of “doctors and men” should be analyzed carefully within the context of a female dominated profession like nursing. It seems that a doctor’s power is not only maximised by their socially recognized role but also by their gender. In addition to evidence reported earlier (referring to doctors as men who do whatever they want), observational findings add a further dimension. It was noted that female doctors, although in the minority, are more cooperative with nurses (both genders) than male doctors. For example, female doctors often prepared the dressing trolley and then clean it by themselves with no or little help from nurses. On the other hand, male doctors rely exclusively on nursing staff to do this for them. How power imbalance between doctors and nurses together with gender related issues might affect nurses’ role in health promotion shapes an important area of the discussion chapter in this thesis.

10.4. 3-Nurses Emigration

Although the lack of time was associated with the shortage of nursing staff at the ward level, it was found that the increasing number of nurses emigrating to other countries have a negative effect on other nurses’ morale within the organisation. Those nurses who cannot go to other countries for different reasons (e.g. lack of experience, family commitments) were left in the hospital overworked. Keeping the

study aim in mind, this might minimize not only nurses' motivation to deliver good care but also their potential role in health promotion. This factor is reflected in the following extract:

"...many very good staff nurses went to Gulf countries. Who could blame them, good money and facilities! Nurses here were left to work harder to [compensate that]. Finally we have some newly qualified staff nurses and I know according to my experience, they will leave us once they get the experience. This ward is for training..." (Surgical ward supervisor).

The above evidence gives insight into the nature of the climate in which nurses are working. The statement "*who could blame them*" might be a recognition of the lack of a supportive environment which in turn could restrict the development of nurses' roles in health promotion at ward level. Improving the financial status could be the primary goal of hospital nurses, which can be achieved by moving to other countries. As outlined above, nurses migration does not only have negative consequences on the shortage of nurses and thus health promotion but also affects them psychologically. This might play a key role in commitment to health promotion.

10.5. Facilitators that might Enhance Hospital Nurses' role in health Promotion

The analysis of responses related to the facilitating factors revealed that such factors are the exact opposite of barriers. For example, more time and nursing staff and the need for specialised nurses in health promotion. There is a need for more nurses on duty so they can better meet patients' needs. Moreover, their knowledge of health promotion needs to be updated. More support from the hospital, strong nursing leadership and flexible hospital policy are beneficial. The overall organisational climate in which hospital nurses work should be kept in mind in relation to the development of their role in health promotion. Thus it is systematically examined in this thesis (See Chapter 11). These were congruent with nurses' suggestions presented in chapter six. Consequently, they are presented here without further exploration. In the light of all responses elicited by focus group discussions with

patients, they suggest that their health can be promoted by a number of factors. This includes: good communication and offering them medical treatment and health knowledge. Some responses reinforce other findings and thus might strengthen the grounds of their credibility. Related to this, the shortage of nursing staff at the time of data collection and the workload were linked to the quality of care being delivered.

“We need more nurses, we see them offering care to a large group of patients and they hardly manage to give even the basic care” (surgical male patient 3)

“We need leaflets and lectures about health related issues. At the time of admission they only ask you about the health insurance and the main problem!” (Surgical male patient 2)

Another participant extended his attention to involve the role of hospital management in promoting patients' health

“I think that the hospital itself should play a fruitful role in health promotion and help nurses. Now in each room there is a TV but they do not show us any thing related to health promotion, just news and drama ” (Surgical male patient 5).

The above evidence is substantiated by those earlier findings, revealing that the insufficient number of nurses is a contributing factor to the care and thus health promotion. This however needs further debate in the discussion chapter. The need for leaflets were seen by patients as a method of health promotion delivery. This might reflect patients' former experiences of health promotion work carried out by nurses. An interesting suggestion to note is the need for better use of resources such as TVs and seminar rooms.

Whilst the comprehensiveness and complexity of health promotion work is recognised, such issues are worth consideration. Field notes about the physical environment suggest that there were some good available resources (at least for health education). However, the researcher was informed by nurses that, for example,

seminar rooms are only used for teaching medical students. The availability of resources therefore does not necessarily mean efficient utilisation . Finally, a good suggestion about facilitating nurses' roles in health promotion is exemplified by the following extract:

“ we need to work together (e.g. doctors and nurses) to deliver health promotion. You know one “hand does not clap” (senior surgical nurse4)

As pointed out by the Arabic verse “*one hand does not clap*” there is a need for collaborative health promotion work. This recognition, despite being recognized by only one participant, is promising. This is because health promotion activities are ineffective unless the planning process and its outcomes are driven by a collaborative approach among different health professionals and across various departments (Tones, 2001, Caelli et al, 2003). However, interpreting the Arabic verse “*one hand does not clap*” as the need for understanding of the collaborative nature of successful health promotion work should be made with care. It is not clear if collaboration is meant here as an essential and legitimate component of health promotion or as a tool to reduce the workload on nurses' shoulders and thus in other words delegate health promotion work to other health professionals. The researcher with a Jordanian background believes that the latter assumption is probably more valid. This is because such an Arabic verse is often used among Jordanians to reduce the pressure of workload created by certain events such as weeding and farming especially in villages. Yet it is an interesting example of the importance of collaborative and multi-disciplinary work in health promotion as emphasised by many authors (Pender, 1996, Naidoo and Wills, 2000, Cullen, 2002, Tones and Green, 2004, Seedhouse, 2004).

10.6 Summary of Factors Affecting the Development of Hospital Nurses' Roles in Promoting Patients' Health

This chapter explored diverse factors that could be involved in developing nurses' roles in health promotion. This includes the lack of time and shortage of staff. Whilst these factors are acknowledged, it was found that many of them were a reflection of nurses' limited understanding of health and health promotion. Yet it seems that hospital nurses work in an unsupportive climate at both ward and organisational level. This is exemplified by "blaming culture of nursing leadership" and the power imbalance between doctors and nurses.

To add to the problem, the nurse's public image is often negative as outlined in this chapter. Job descriptions and responsibilities allocated to nurses together with the nursing philosophy are indicative of little attention given to the more recent ideal health promotion guided by the empowerment approach and political actions. These findings complement others from previous chapters and form a framework against which the overall working climate of hospital nurses is examined in the discussion chapter.

Whilst the factors that might interplay with nurses' roles in health promotion are complex, identifying them is a prerequisite for establishing certain strategies to address them. Driven by such factors together with related evidence from this study and international literature, a conceptual model about hospital nurses' role in health promotion is developed in the following chapter. The model might help in tackling inhibiting factors at different levels that contribute to the development of hospital nurses' role in health promotion in Jordan.

However, the credibility of these factors needs to be validated by triangulated data. The analysis shows three types of data triangulation, i.e. confirmative, complementary and contradicting. The lack of time and shortage of nursing staff was confirmed by FGDs (n=4) with patients, FGDs with nurses (n=4), individual interviews (n=4) as well as observational data. Such barriers are more likely to affect

the development of the surgical nurses' roles in health promotion than their counterparts in medical wards. This is validated by the significant findings from the questionnaire. Quantitative evidence however needs to be interpreted with care as the sample involved was dominated by medical nurses (65%, n=35). These factors could inhibit the development of nurses' roles in health promotion at the ward level.

Qualitative findings were confirmed by quantitative evidence and added further clarification. Related to this, problems associated with nursing leadership and doctors were illuminated by the FGDs with the nurses, the surgical ward supervisor and the nurse educator. The external validity of this theme was enhanced by the evidence from the questionnaire. It was found that 62% (n=36) of respondents felt that the nursing leadership was influenced by doctors in general. The overall analysis indeed offers new and interesting factors that could be contributing to the development of nurses' roles in health promotion.

This involves organisational culture and gender issues. The philosophical influences and organisational hierarchy might be the most complex cluster of factors that could severely restrict nurses' role in health promotion regardless of the availability of time, the number of nurses on duty and presumably the nature of nursing education. Related to this, the adherence of nurses to the medical model which resulted in little development in health promotion could be explained by the philosophical issues informed by a task-orientated approach. The available courses in the hospital, observational findings and the perception of ward supervisors support the existence and continuity of such a philosophy of care. That is the focus on treating illness and preventing complications.

These task orientated interventions are consistent with the values of the medical model of health as opposed to a wide reaching health promotion vision operating at the level of structural sphere holistic health (Pender, 1996, Tones, 2001, Casey, 2007) . However, this philosophy of care is largely integrated into nurses' job descriptions which have not been updated for a decade. In other words, the question that might be asked here is how can a newly qualified nurse challenge a philosophy

that was in operation for years? Given the lack of power nurses might experience at the hospital in comparison with doctors, the above task seems to be unachievable. In fact, the outcome might have a disempowering effect on nurses' morale and motivation. This in turn might militate against the utilisation of the self-empowerment model as an essential component of health promotion. The interview with the nurse educator suggests that the newly qualified and motivated nurses are often confronted with harsh reality at the hospital exemplified by a hierarchical relationship with senior staff. Indeed, the public image of nursing is low according to surgical nurses and the medical ward supervisor. Thus, nurses' roles in health promotion might be constrained by the image of the nursing profession itself.

Previous studies (Furber, 2000, Cross, 2005, Irvine, 2007) demonstrate that the lack of time, resources and ineffective education in health promotion are key factors that could inhibit the development of nurses' roles in health promotion. These factors are acknowledged here but the situation is much more complex than it appears in this analysis. This could be due to the complexity of the health organisation where different people have different roles and degrees of power and thus autonomy. It can be argued that the adequate resources and the availability of time and good education does not necessarily mean that nurses' roles in health promotion will be better developed. It seems that the root of the problem might lie in the organisational hierarchy and philosophical influences. Thus, there is a need to re-orientate the whole organisation and its underpinning philosophies and missions towards health promotion. Eventually, it would appear that the level of articulation between the needs identified at the ward level and the support offered at institutional and national level might provide an indicator of level of reforming nursing care towards health promotion. This is to be discussed in the following chapter

Chapter Eleven: Discussion

11.1 Study Strengths and Limitations

This is, to date, the largest international and the only Jordanian study that attempts to understand exclusively hospital nurses' role in health promotion and factors involved from different perspectives. Its main strength therefore stems from its originality and the utilisation of a wide range of methods to address a complex phenomenon in the natural setting. Unlike many of the earlier studies (McBride, 1994, Maidwell, 1996, Cross, 2005, Casey, 2007, Whitehead et al, 2008), not only what is perceived as health promotion is examined among hospital nurses but also what is carried out in its name. The study therefore offers more systematic evidence which might better guide practice and future research.

However, caution must be applied and considerations must be given to the methods and study design. Mainly, qualitative research has been criticized on the ground of ignoring issues of validity and reliability and for being anecdotal (Benton, 2000). The reliability of this work was enhanced by methods triangulation and respondents checking of findings (Trustworthiness of data). The strength and weakness of each method and the overall design were acknowledged and measures to minimize the threat of credibility of this work were taken (See Chapter sections 4.11.4).

The health care system in Jordan is complex. It involves four different sectors. Private hospitals, public hospitals, military hospitals and hospitals affiliated university. The study involved only one hospital affiliated university. Given the nature of the organisational structure, training opportunities for staff and budget allocation, vigilance must be exercised against extrapolating the study's findings to other hospitals. The findings however might be considered as a benchmark against which multiple case study design is developed in the future and thus sharpen the generalisability of this work. In other words, the study should be considered as a beginning rather than an end point of this generation of empirical investigations.

Regardless of the nature of methods used and the study's Middle Eastern context, there are similarities with previous international research suggesting that hospital nurses worldwide face common challenges. It would appear consequently that collaborative research and trans-cultural studies are needed to guide global strategies addressing diverse challenges in the health organisation (see below). That is, "there is an urgent need to develop internationally comparable data on health promotion" (Mittelmark, p101, 2007). The current work reacted to this need and contributed to the limited pool of evidence in this area.

11.2 Culturally Competent Health Promotion Activities: Implications for Practice

An interesting finding to note is the variation between nurses' understanding of health and health promotion and patients' own views and expectations. Patients in this study paid more attention to the role of religion and spirituality in influencing health gain and seeking health behaviours than nurses themselves. Although holistic care recognizes the importance of physical, psychological, emotional, socio-cultural and spiritual aspects of care (Govier, 2000), the latter is often neglected in nursing practice (Ross, 1996, Dossey, 1998) and largely is offered in an unsystematic and haphazard way (Leeuwen et al, 2006). Likewise, these findings reinforce earlier nursing (Yaoho and Ezeobele, 2002) and medical studies (Ogden et al, 2002) revealing that patients, nurses and doctors share different understanding of holistic health which could affect the process of promoting health itself.

However, when it comes to spirituality and religious activities such as praying, patients in this study are interested in this aspect of care. Religious involvement in care is correlated with decreased morbidity and mortality (Matthews et al, 1998, Oman et al, 2002), is associated with up to 7 years longer life expectancy (Helm et al, 2000), had a beneficial impact on blood pressure management (Walsh, 1998) and might help patients to adjust to socio-economic problems (Van Poppel et al, 2002). The study adds a further dimension. According to some patients, they felt less stressed when they accepted their fate and kept praying. More specifically this is in

line with earlier research indicating that Islamic based psychotherapy is effective in minimising anxiety and depression in Muslim Malays (Razali et al, 1998).

Evidently the role of religious activities might affect the overall quality of life and they could be better addressed in the health care setting like hospitals. Health care providers therefore are urged to better understand patients' religious background, identifying how their beliefs might be used to cope with illness (Lee and Newberg, 2005).

Using the "five Rs of spiritual care" proposed by Govier, (2000) might be a useful tool to explore patients' needs of spiritual care. This includes, Reason (the purpose of life), Reflection (reflect on the experience of illness), Religion (the framework in which individuals express their spirituality), Restoration, (the way spirituality affects health). Although these elements need to be examined fully from different faith perspectives, they offer a foundation to explore the needs of patients.

Nevertheless, a word of caution must be sounded here. Whilst spiritual care is needed, patients should not be exclusively encouraged to focus on religious belief and ignore medical treatment. This could lead them to think that poor faith is the cause of their illness (Sloan and Bagiella, 2002) and thus minimise their adherence to the prescribed treatment plan.

It is crucial therefore those health care providers offer a balanced approach, medically oriented interventions and informed by spiritual care. By incorporating what patients' believe about health and health promotion into the framework of care, a high quality of life can be achieved together with treatment compliance (Yaoho and Ezeobele, 2002, Lo et al, 2002, Hjelm et al, 2005).

11.3 The Philosophy of Care and Hospital Nurses' Practice of Health

Promotion : Limited Progress Made and Key Challenges Remain

The overall evidence from the study reveals that hospital nurses operate within the framework of health education focusing on individualised behavioural change approach as opposed to health promotion encapsulating empowerment and advocacy. These findings are congruent with many previous studies (McBride, 1994, Cross, 2005, Casey, 2007, Irvine, 2007). Yet a more recent work by Whitehead et al, (2008) contradicts the emerging evidence. It was found that hospital nurses had a wider understanding of health promotion and their “perceived” practice is in line with the modern health promotion principles.

This inconsistency however should be interpreted with care. The methodology of Whitehead et al's study together with its conclusions is limited by a number of factors. As no observational data were elicited, nurses' actual health promotion can be debated. Indeed, Whitehead et al's study was based on a very small sample size (n=8) and thus drawing a definite conclusion about their understanding of and practice of health promotion is a difficult task. With these limitations in mind, it can be argued that internationally hospital nurses have made a limited progress to date towards a more systematic and empowering role in promoting patients' health. The question to emerge therefore is why has the potential of hospital nurses in health promotion not yet been realised? Even in more developed countries (e.g. UK, USA) where the education pays significant attention to health promotion, nurses' role in health promotion is still questioned (Furber, 2000, Cross, 2005, Casey, 2007, Kelly and Abraham, 2007).

Previous research referred to management and organisational issues as contributing factors to hospital nurses' role in health promotion (McBride, 1994, Cross, 2005, Whitehead, 2008). Their methodologies however are superficial and inappropriate to uncover complex and overlapping issues of significance to hospital-based nurses' role in health promotion. The complexity of factors reported earlier (Furber, 2000, Cross, 2005, Casey, 2007) might be constrained by nurses' own interpretations of

health promotion. For example, the lack of time is a well documented international factor that could shape nurses' role in health promotion (McBride, 1994, Cross, 2005, Casey, 2007). This factor is acknowledged but its frequent emergence in the research might be due to nurses' understanding of health promotion as an interpersonal activity as opposed to complex health promotion work operating at different levels. That is, individual, organisation and community. The effect of time on the overall quality of care is explored in this chapter (See Section 11.5).

The fact that nurses operate at the level of health education mode as opposed to health promotion is now globally well documented (Maidwell, 1996, Whitehead, 2004, Cross, 2005, Irvine, 2006) and substantiated by this thesis. It was decided therefore that the discussion chapter will not reconstruct a problem with a different terminology and labels (e.g . nurses' limited role in health promotion, medically orientated role). Such an approach addresses only symptoms rather than causes. Instead, this discussion focuses on underlying factors that might inhibit the development of nurses' role in health promotion particularly those related to the organisational culture. That is in case study research:

“It is often more important to clarify the deeper causes behind a given problem and its consequences than to describe the symptoms of the problem and how frequently they occur” (Flyvbjerg, 2006, p 229).

11.4 Power Imbalance between Doctors, Nurses and Patients

Based on this research, perhaps the most complex inhibiting factor that could affect the development of hospital nurses' role in health promotion is related to the imbalance in power between doctors and nurses. The problem however is not as simple as the headline might suggest. It is a multi-dimensional issue encapsulating diverse and overlapping elements. This includes the public image of nursing, nursing and gender and the 'power over' approach used with patients. To date such issues have not yet been fully understood and their impact on the development of hospital nurses' role in health promotion is open to debate. Specifically, there is paucity in the

literature about the lack of nurses' professional power as a factor limiting the development of nurses' role in promoting patients' health.

To better understand how the overall climate of the hospital exemplified by the lack of power among nurses can interfere with nurse's role in health promotion, it was decided to frame the analysis from different but interrelated perspectives. These are given below.

11.4.1 Nursing Struggle for Power

There are two types of power struggles identified in this research. Whilst the first is related to power imbalance between doctors and nurses, the second is concerned about hierarchical power among nurses. These are elaborated below.

Nurses, the manager of training and development and ward supervisors all have expressed their dissatisfaction about their ability to make decisions or participate in decision making within the hospital organisation that is dominated by a powerful discipline like medicine. Being professionally inferior to doctors within the hospital setting was reported by some nurses. That is, findings from this work suggest that nurses do not have adequate power to reinforce their actions. This is exemplified by inability to make decisions about general treatment plans such as discharge time and secure funding for health promotion.

These findings however are consistent with previous research pointing out that the unequal power base still exists in the health care system as doctors are seen at the top of the hierarchical structure followed by nurses, nurse helpers and unskilled workers at the bottom (Philips and Zelek, 2003). Evidence from this thesis reveals that patients and their families are likely to be among those at the bottom. This is explained further in the subsequent sections. The causes of imbalance in power between doctors and nurses are diverse but many are not new. Historically, the doctor- nurse relationship is unequal and exemplified by the dominance of the doctor with the nurses assuming the lower status (Nilson and Larson, 1999, Qolohle et al,

2006). The two professions are historically imbued with particular gender relationships built upon certain notions of femininity and masculinity which still leave their marks on the decision making process (Davies, 2003).

In addition to gender related issues, educationally speaking, medicine and nursing are based on different philosophical perspectives. Medical education and training emphasizes authority within the organisation, whereas nursing education often focuses on the quality of care (Gjerberg and Kjolsord, 2001). Whilst the standard of care needs authority to locate resources and staff, medical power shapes the nature of power needed to achieve this (Coeling and Cukr, 2000). Likewise, the lack of power among nurses and influence on the global policy scene has been documented in the literature (Sinivaara et al, 2005, Koprak and Tabak, 2007) and noted in the Jordanian health care system (Oweis, 2005). Nurses' limited ability to express their issues and needs to the hospital management dominated by medical professionals has been outlined by the manager of training and development. Findings from this work therefore cohere with those of Davies (2004), nurse voices are not sought and if they are offered, they are not listened to.

Research has shown that because of their income, social and professional prestige and authority doctors reinforce their dominance in health organisation (Philips and Zelek, 2003, Sinivaara et al, 2005). This is not only confirmed by the perceived lack of support offered by the hospital management to hospital nurses in comparison with doctors but also by some observation in this research. The morning rounds can be taken as an example. It was noted over the data collection period (6 months) that when the medical team approaches a patient's room, the consultant takes the lead followed by doctors and the lowest position in the hierarchy comes in last. This was often a registered nurse holding a medical record including mainly lab results and medication index. Such behaviours were not a result of haphazard formation. The sociology literature in health organisations argues that space and place have unequivocally spelled out status and position (Davies, 2003). The author noted similar behaviour in western health organisations. It seems therefore that the imbalance in power between doctors and nurses and its behavioural manifestations

are not restricted to hospitals nurses in this study. These observations sit well with the argument that hospital nurses submission and obedience might take different forms (Peter, 2004). These behavioural manifestations confirmed the argument that power imbalance between medicine and nursing indeed exists in the organisation and is likely to lead to top down communication approaches (Davies, 2003).

In Jordan, doctors' orders are highly respected and some nurses might find it difficult to challenge them in hospitals (Mrayyan et al, 2005). It was also noted that nurses in Jordan might have conflicts with doctors especially about medication related plans due to the power imbalance (Oweis, 2005). This is mirrored in the current research as some nurses felt that not adhering to the doctors' instruction would create problems with them. As a result nurses felt that sometimes they had no motivation to participate in decision making about patients' care. This presumably would affect nurses' ability to reflect their role in health promotion into the framework of daily care.

The findings of this work reveal that some nurses give more priority to get the nursing work done which revolves around task oriented actions as opposed to promoting positive health. Concerns were expressed by nurses regarding their inability to initiate a discussion with doctors about doctors' ineffective practice. For example, it was reported some doctors do not communicate with patients and nurses, but eventually nurses will be blamed by doctors if things go wrong. Although such findings are not generalisable, they illuminate the fact that the imbalance in power between doctors and nurses is likely to threaten the principles of patients' care due to the lack of two way communication and multi-disciplinary team work. In other words, patients might be victims of a power imbalance between doctors and nurses and hierarchical structure as discussed in the following section. On the part of nurses, the effect of such complex hierarchical relations is systematic and worth consideration. Logically health promoters themselves need to have good health in order to offer optimum care for others.

Against this however power associated conflicts with doctors are not only a key source of stress for nurses but also are more harmful than other sorts of interpersonal conflicts (Hillhouse and Adler, 1997), can lead to psychological ill health among hospital nurses (Ahmed et al, 2003) and are associated with job dissatisfaction (Stordeur and Dhoore 2006). On this basis, not only the quality of health care might be compromised but also the overall health of nurses.

Whilst what doctors do in the name of health promotion is not the focus of this research, the medical literature argues that it is rarely prioritised on their agenda (Hulleman (2006). The scholar argues that the idea of health promotion within the hospital is often favoured by administrative and nursing personnel with little attention given by doctors.

Likewise, a recent empirical work shows that doctors seem to prefer ordering investigations to giving verbal health advice and intuitively assume others (e.g nurses) to provide the latter (Sammur, 2006). The lack of attention given to health promotion or at least giving verbal advice by doctors might be explained by their exclusive focus on technical expertise (e.g micro-surgery) which is often needed to further their social prestige and respect accorded to them in the organisation (Guo et al, 2007). Although the evidence is inconclusive, the above argument is congruent with observational findings emerged from this research.

Observational data revealed that doctors were always absent at the time of discharge plan of their patients. The main contribution they make is related to the preparation of discharge letter. Basically, even giving health advice (e.g medications and their side effects) was left to be done by nurses. Thus, despite their powerful position, doctors might be more interested in curing illness than promoting health. This argument is aligned with the international concern that medical doctors are now more interested in a particular type of scientific expertise which often leads to promotion in the career ladder and social recognition (Corser, 2004). Whilst of course health promotion needs to be guided by scientific expertise, the reality is that developing

clinical and advanced curing skills could be given more attention within the health care system (Seedhouse, 2004),

It seems that the extent to which doctors advocate nurses' role in health promotion is undefined. There is therefore an urgent need to examine doctors' attitudes towards nurses' potential role in health promotion. This is an important area of research as nurses need to work collaboratively with doctors as part of their multidisciplinary cooperation in health promotion.

Whilst the limited role of nurses in health promotion might draw a bleak picture about their practice in this work, there are some good examples of health promotion worth noting. Diabetic nurses demonstrated better understanding of health promotion and structural determinants of health. Whilst the context of ward nurses and diabetic nurses is different, the latter felt more confident in dealing with patients and negotiating with doctors than their counterparts in surgical and medical wards (e.g. rejecting unclear treatment plan). It should be noted that education is often correlated with competence (Morgan and Clave-Hogg, 2003) and both elements are associated with confidence and motivation (Mann 1999). Taking these elements together, it is possible that diabetic nurses who hold an extra qualification were more competent in promoting patients' health.

Given medical power, authority and social status, the possibility that diabetic nurses acquired such elements from the diabetic consultants through training and association cannot be ruled out. That is, unlike their counterparts in surgical and medical wards, the power and thus the autonomy of medicine were delegated to the diabetic nurses and might have shaped their practice, enhanced their self-confidence and their ability to mobilise resources. This argument ties with organisational literature indicating that professional power might be transferred (delegating and associating the tasks) to the followers and affects their performance (Davies, 2003). In the same context, powerless supervisors might contribute to their nurses' limited ability to make decisions (see above). It can be argued therefore that diabetic nurses

have been armed with some medical power which in turn has shaped their behaviour and maximised their educational and training opportunities.

Taking the evidence as a whole, it would not be surprising that the imbalance in power base between hospital doctors and nurses might play an instrumental role in the lack of development of the nurses' role in health promotion within the hospital setting. The psychological effect of the inability to make decisions (e.g. about treatment plan) on nurses' self-concept, and confidence should not be underestimated. Hospital nurses might not be comfortable in broadening their role in health promotion due to the lack of organisational support and thus ability to make change. It is not however the organisational system alone which most impacts on care processes and outcomes but the ward culture and staff attitudes (Adams and Bond, 2001). This brings the debate to other issues.

11.4.2 Power Imbalance Among Nurses

In addition to the power imbalance between doctors and nurses, findings from this research reveal that nurses are managed at the ward level in a hierarchical and authoritative way. Nurses expressed their dissatisfaction in their nursing leadership. They reported that ward supervisors are here just to "*search for our mistakes*" and thus to blame them. Evidence further suggests that when nursing problems occur on wards (e.g. drug errors), supervisors often support doctors against their nurses. Although these findings have not been confirmed by observation, they are congruent with earlier research (Chang et al, 2002). The researchers found that nursing managers are clinging to doctors to gain more power and possible promotion but this does not necessarily improve their relations with their staff (Chang et al, 2002). The supportive leadership at the ward level is associated with an increased learning motivation and high quality performance (Scott and Moye, 2002, Mula, 2003) and thus nurses' role in health promotion might be developed and maximised.

Against the backdrop it was found in this study that newly qualified nurses confront an unsupportive nursing culture. This is also validated by FGDs with junior nurses.

Some reported that when they started working at the hospital, they used to arrange health education activities for patients but they cannot do it again due to the lack of ward supervisor's support. In other words, they are often required to adhere to what senior nurses do. As Daiski (2004) states "sadly it remains that a good nurse is one who accepts their place in the hierarchy and learns to do things the way it is done here" (p49). Hamlin (2000) is critical of this problem and goes further to describe nurses as "eating their young". Due to the lack of strong evidence from this work this description needs to be taken with care and is of course worth further research investigation.

However, the hierarchical nature of the nursing profession itself which stresses discipline authority and punishment is the main barrier to gain equality with other health professions (Takase et al, 2001). In confirmation with evidence from this work, it is argued that to survive in a high stress position, vulnerable nurses are socialised to respond submissively to those who have power over them and too often responding negatively to their subordinates (Randle, 2003). In this context therefore the power structure among nurses at the ward level might restrict the capability of junior nurses to translate their taught knowledge and skills into practice.

Whilst having a better education base is essential for effective leadership (Scott and Moye, 2002), it is surprising that evidence from this research contradicts this notion. It was found that those graduates with even higher education often struggle to have a decision making position in the organisation. Together with evidence from this thesis, the human capital theory might offer some explanations (Becker, 1962). The theory refers to the notion that in the absence of more direct measures of productivity in health care systems, employers use indicators such as years of experience to gauge the potential of an employee. In this context those nurses with greater number of years experience are seen to have acquired an "on-the- job" education of value to an employer. It is still used as a criterion for job promotion (Brown and Jones, 2004) and its applicability to the current work is reinforced by the research.

According to the nurse educator, many nursing leaders in the hospital lack leadership skills (e.g managing staff) due to limited continuing education. These issues might create problems to the new generation of nurses who might be better educated. Thus, the ward culture was authoritatively led and hierarchically structured in which nursing staff might find it difficult to realise their potential in health promotion.

Consequently, on the one hand, nurses have a power struggle with doctors; on the other hand, they do not support each other to address their needs and concerns within the organisation. As a result it is not surprising that their voices might not be heard by the hospital management due to divisions and possibly interdisciplinary conflicts among themselves at the ward level. This sort of conflict is in its own right at odds with the ideology of health promotion amending the values of cooperation, coordination and intersectoral work.

However, one could wonder how having professional power within the organisation could constitute to the development of nurses' role in health promotion. Simply, is power a fundamental need or secondary to their role in health promotion?

Before answering these questions and highlighting implications for practice, it might be useful first to look at broader factors that might prevent nurses from enjoying power within the organisation. Some factors such as doctors' authority, hierarchy among nurses and the lack of organisational support were commented on earlier. However, being somewhat powerless in the organisation might be associated with broader issues such as the gender problem and public's image of nursing. These are discussed below along with possible resisting and coping mechanisms carried out by nurses.

11.4.3 Nursing, Power and Gender

Till now the nursing profession has been dominated by women and men are still a minority. Men comprise 10.2% of registered nurses in the UK (Oxtoby, 2003) and 5% of the registered in the USA (Needleman et al, 2002, Qolohle et al, 2006). By contrast, the number of men who joined nursing programmes in Jordan has

dramatically increased where about 65% of nursing students are male (Mrayyan, 2006). However, this might not reflect the ratio of male to female nurses in the Jordanian hospital. Due to economic constraints male nurses find it easier and culturally more acceptable to emigrate to other countries.

Findings show that many male nurses travel to others countries as economic migrants. It should be noted that in Jordan men are the main breadwinners and this is substantiated by evidence from FGDs with male patients. Given these issues, it is not surprising that nursing workforce in Jordan is dominated by women (Male 40%, female 60%).

It is recognised that health care systems in many countries (Philips and Zelek, 2003, Davies, 2004) and in Jordan (Oweis, 2005) are dominated by doctors. Evidence from this research suggests that gender stereotypes are also of relevance to power imbalance between doctors and nurses. The manager of training and development pointed out that “doctors” do what they want in the hospital and then that ‘doctors’ and “men” have been used by herself interchangeably in the interview.

Whilst the numerical dominance of male doctors in comparison with female doctors cannot be ruled out, it seems that the imbalance in power between doctors and nurses is based as much on gender as on professional hierarchy. The examination of related literature in organisation and gender and women’s roles in the society worldwide and in Jordan elaborates further the above. Theories about gender suggest that women’s experience of child-bearing and caring is a dividing line between women and men (Alvesson and Due Billing, 1997). This fundamental difference affects their roles in the society. In the Middle East region, the role of health care providers was traditionally part of the role of women but only for their family (Tumulty, 2001). Thus, caring was learnt within the context of family with no or little power to resist the norm. Female patients in the study were more interested in teaching their family about health than male patients. Indeed, whilst male patients were concerned about the economic status as breadwinners, female patients made reference to the importance of working at home.

However, one study carried out in Qatar and Kuwait has shown that Arab women are willing to accept more responsibilities in the political, occupational and social spheres but men were less willing to share such responsibilities with them (Abdalla, 1997). Although the study is a decade old and needs to be replicated with a more diverse sample to verify their findings, it underlines the power imbalance between two genders in the Arab society and worldwide (Alvesson and Due Billing, 1997).

In view of the above, it is no wonder that female nurses struggle in the Middle East to achieve professional status as it is complicated by the dependent role of women in the society (WHO,1998, Tumulty, 2001) and this situation might be transferred to the organisation (Daiki, 2004). This fits well with the argument of Davies (2003) that health care systems are not gender-neutral, they are strongly patriarchal and such a culture does not allow substantive growth for women. That is, nurses might have limited power in the organisation not only because of the hierarchy but also because of social expectations of women' roles. Because of this however, it is proposed that women as nurses are rated as being more popular when they behave in gender role congruent manners such as being quiet and caring (Philips and Zelek, 2003, Mohr and Wolfram, 2007). These features are desirable to a health care system dominated by men (Sczensy et al, 2004). On this basis, whilst their caring role is recognised, they might not be able to take decisions and be involved in organisational debate and policy formulation.

Further examination of findings indicates that the imbalance in power between doctors and nurses might be strengthened if nurses work with male doctors. In addition to evidence reported earlier (referring to doctors as men who do what they want), observational findings add a further dimension. It was noted that female doctors although in minority are more cooperative with nurses (both genders) than male doctors. For example, female doctors often prepared the dressing trolley and then cleaned it by themselves with no or little help from nurses. On the other hand, male doctors rely exclusively on nursing staff to do this for them.

Whilst addressing specifically the interpersonal relationship with doctors is beyond the scope of this work, these observational findings resonate with the international research. It was found that nurses generally experience satisfaction when they communicate with female rather than male doctors and women doctors are perceived to be less demanding and more consultative (Pringle, 1996). Recently it was found that when both nurses and doctors are female, power imbalance between the two diminishes (Zelev and Phillips, 2003).

Although the male-male relationship within the organisation can be led by a competitive approach (Davies, 2003), no evidence was found related to power relationships between male doctors and male nurses. This might be related to the number of male nurses in comparison to their counterparts. In line with the findings of this research, nurses regardless of their gender have little access to power within the male and medically dominated health care system (Littlewood and Yousuf, 2000). It seems therefore that power is determined by masculinity as well as socially structured roles (see above).

With the growing number of male nurses in Jordan, one might argue that if nursing in Jordan is dominated by males, the profession might gain more power within the organisation. Interestingly, in the USA, it was found that men move into the higher positions when they enter a female dominated caring occupation (Brown and Jones, 2004). It is suggested that men's rapid promotion and achievement may be related to gender based leadership in the organisation. However, male nurses by virtue of their participation in feminine work like nursing may not measure up to the standards of socially constructed masculinity manifested by power and socially high status (Connell, 1993). Given the number of male nurses, the question of cultural domination rather than numerical domination needs to be considered (Evans, 2002).

That is, culturally nursing might be considered as women's work regardless of the number of men entering the profession. Nonetheless, gender relations are complex and do not lend themselves to "quick fixes" (Kane and Thomas, 2000). As a result nurses need to acknowledge gender relations as well as roles involved in the society

and organisation. The implication therefore that there is a need to incorporate such elements in nursing curriculum which internationally (Corser, 2004) and in Jordan focuses mainly on the nursing care related issues (Oweis, 2005).

Whilst gender issues are acknowledged here, it is important to remember that gaining more power within the organisation is a national challenge that cannot be taken up by female nurses or male nurses alone. Meaningful change at both organisational and national level requires both genders to work hand in hand to achieve their ambition and social status. It is the time for the nursing profession to address gender issues and face organisational challenges such as the lack of power. This might be addressed by effective networking between nurses, the Minister of Health in Jordan and importantly the Nursing Council. It seems that studies are needed in the future to examine the pattern of relationships between doctors and nurses, taking into account gender issues. The literature in Arab countries offers views and suggestions but has not been a subject for sufficient empirical investigations. Many questions are still unanswered even in the international literature. How could such gender shifts affect communication, team work and decision making? How could the use of power within the organisation affect a profession largely dominated by women? These questions are of importance to health promotion given its multi-disciplinary nature.

11.5 The Shortage of Nursing Staff within the Organisation

A further organisational and contributing factor that interferes with the hospital nurse's role in health promotion is related to the shortage of nursing staff. This problem in its own right has a cluster of interconnected factors related to nurses' emigration and the availability of time for health promotion.

Findings from this study indicate those nurses' migration to other countries affects not only the workload and thus time for patients but also the morale of staff. Nurses' migration often leaves behind an already disadvantaged system, thus worsening the working conditions for nurses (Kingma. 2000, Chikanda 2005, Dovlo 2005, Ross et al, 2005). This affects the mix of skills and the way tasks might be delegated and

implemented. The lack of nursing staff was evident especially in surgical wards where the rhythm of work is fast and many cases need extensive care.

The replacement of those who have emigrated is problematic. According to the manager of training and development, they are often the most experienced ones who are difficult to be replaced. When new graduate nurses are employed, they require to complete the supernumerary period (3 months) before they carry out complex tasks independently. However, evidence from this research reveals that when newly qualified nurses gain experience; they are likely to follow the steps of previous colleagues and emigrate.

Thus, whilst those who might not be able to emigrate might have better promotional opportunities, they need to compensate the lack of staff and offer training to newly employed nurses. This eventually could affect the time dedicated to patients. It was found in this work that Jordanian nurses travel to other countries for better pay rates. This is consistent with the economic theory - at its basic level. It suggests that the movement of resources is predicted by different prices (Krugman and Obstfeld, 2003).

Yet economic theory is rather oversimplifying the problem. Emigration among nurses would occur even in the absence of wage differentials (Massey et al, 1993). Evidence from this thesis argues that the turn over and retention among hospital nurses in Jordan is influenced by the overall working environment (e.g. power imbalance, workload).

Likewise, nurses might emigrate because of an employment rate (Rose et al, 2005) the size of emigrant population in the receiving country (Hatton and Williamson, 1998) the primary language used where they emigrate (Frankel and Ross, 2002) and where the receiving country offers better professional development opportunities (Buchan et al, 2003). Although there is a lack of statistics, these motivating forces reflect the situation in Jordan where many nurses travel to Gulf countries (AbuAlRub, 2007).

There is therefore a need for serious commitments from health organisations and policy makers in Jordan to address not only nurses' salary related issues but importantly the nature and causes of their disempowering working conditions as explored in this work. However, a question needs to be asked here: Will health promotion work improve if we have more nurses on wards? Does the number really matter?

The literature reveals some conflicting data on the link between adequate nursing staff, the availability of time and the delivery of care. Growing evidence found that the low staff ratio of nurses decreases job satisfaction and increases stress (Williams, 1998, WHO, 2001, Chikanda, 2005, Abu-Alrub, 2007) associated with poorer quality of nursing care and leading to a higher patient mortality (Aiken et al, 2002).

Conversely, recent but limited evidence found that more nurses on wards does not necessarily lead to higher standards of care (Adams and Bond, 2003). The same scholars found earlier that the level of competence and the mix of knowledge and skills of nurses are powerful in maximising or otherwise the quality of care (Adams and Bond, 1995). Other scholars argue that nursing leadership at the ward level is a key factor in offering high standards of care (Scott and Moye, 2002). Synthesising the above arguments together, it seems that responding only to the shortage of nurses by increasing their numbers might not be an effective strategy to deliver holistic care and health promotion. The ward remains the most organisational unit of working but its ward cultures can be dissimilar even in the same hospital as is the case in this study. Evidence from this study reveals that some nurses used their time better than others in exploring patients' concerns and thus creating opportunities for health promotion work.

Therefore whilst there is an acute need to offer hospital wards with adequate nursing staff, it is critical not only to focus on the quantity but also quality, together with what happens on wards in relation to the use of nurses' time. For example, there were episodes of silences while changing the dressing on a diabetic foot. These can be seen as missed opportunities for at least health education. In this context, the

formula of perceived workload and the number of nurses on duty should be approached carefully.

More analysis should be given to the competency level of nurses, the nature of leadership at the ward level, the availability of resources, the nature of cases (e.g level of dependency) as well as the mix of nurses (junior: senior). Further research is needed to examine how such factors might contribute to the quality of care as well as the development of nurses' role in health promotion.

11.6 Nursing and its Public Image

Although how the Jordanian public view nursing is not the aim of this research, some empirical indicators suggest that exploring such issues is worthwhile. Nursing supervisors and ward nurses pointed out that some patients prefer to communicate with doctors instead of nurses. It was also suggested by the medical supervisor that the public still offer more respect to doctors, who enjoy more social prestige and power.

Interestingly, when Jordanian women's ideas for their first baby's future were explored, women expressed the wish that they should have a higher education such as medicine (Safadi, 2005). This evidence is substantiated by a recent Jordanian work showing that the nursing profession was not the first choice of career for many nurses due its poor public image (Shuriquie et al, 2007). A nurse in the focus group discussion offered some insights into how images about nurses could affect them and thus their role in health promotion. It was mentioned that people prefer doctors to promote their health as they see nurses as not educated. The participant stated that even when we have a university degree; some people call us "Tamrjeh". This classic Arabic title refers to those aid workers in the sixties and seventies who lacked knowledge, skills and clear job description. They were completely controlled by doctors, mainly males, who are publicly perceived as powerful and wise. It seems therefore that the poor image of nursing has been culturally constructed in Jordan over the years.

Internationally, although Lusk (2000) contends that nurses have developed a responsible and autonomous role, the media image is that all many nurses look for is fun and romance (Hallam, 1998, Tang et al, 1999) and behave in a submissive way towards doctors (Fletcher, 2007). Socially whilst physicians were ranked number 1 in the USA, nurses were ranked 91 on a ranking prestige (Kalish, 2000) and nursing was seen as a low status profession (Seago et al, 2006). On this basis, it is surprising that the majority of hospital patients in this study attribute value to nurses and particularly their role in health promotion.

Whilst it is recognised that the interviews were scheduled around health promotion and study objectives, no negative images about nursing itself were reported by participants. This however needs to be explained by the nature of participants who are already hospitalised. Although the public image of nursing might be negative and thought of as low status work, it was found that people in Jordan value nurses when they are admitted to the hospital and experience their role of care (Oweis, 2005). That is, after experiencing an admission they are more aware of nurses' skills and knowledge than those who are not familiar with what they actually do. A further explanation might be related to the background of the moderators of the focus group discussions. As they were nurses, participants might have felt that expressing a negative image about nursing as a profession is not appropriate in that situation. It should also be noted that whilst focus group discussions are a valuable research method particularly in establishing consensus among participants, their external validity is threatened by the small sample size. In other words, the sample in this study might not represent the views of the public towards nursing in Jordan.

Further research therefore is needed to examine how the public in Jordan view the nursing profession. All the above might indicate that before nurses are urged to act as health promoters, it is imperative to explore the public image of the profession itself. The way in which the low social status of nursing affects the development of hospital nurses' role in health promotion is a complex phenomenon. It is postulated that the public's stereotypical image could affect decision makers' views towards the nursing profession (Fletcher, 2007). Arguably, the public's opinion is very powerful in

determining the social structure and norms and could cause an oppressive environment in health care settings (Roberts, 1997).

Whilst personal interaction during hospitalisation may involve individuals' understanding of nursing, their beliefs and experience cannot be translated automatically into wider social beliefs of nursing (Buresh and Gordon, 2000). On the other hand, if such experiences are shared more widely among members of society it is likely that nursing would gain more social respect (Haslam, 1997). Accordingly, without mass media support it is difficult to convey a positive image of nursing to a wider population.

Utilisation of the media in Jordan by nurses might be an effective method for addressing the negative image of the nursing profession (e.g. handmaiden of doctors). For example, there is a need for a drama series to show the public what nurses do, their skills and contributions to the quality of care. The drama need not use the term "Tamrjeh" to refer to nurses as it seems such label has a negative impact on the profession.

A suitable use of drama may influence governmental and policy makers to locate the resources needed for the development of nursing profession (Berry, 2004) and keep nurses' issues on the social and political agenda (Wellings and MacDowall, 2000).

That is, in order to inhibit a stereotypical undesirable image of a social group; there is a need to redirect the focus of the society on other aspects of the group which exhibit desirable images (Dunn and Spellman, 2003). Taking this argument further, hospital nurses with the help of their organisation are urged not only to educate the public about health but also about their own profession. Whilst organisational obstacles are recognised (see above), once hospital nurses have gained social recognition, people's receptivity to their role in health promotion might be maximised.

11.7 Hospital Nurses and the Current Working Environment

Hospital nurses in Jordan and perhaps worldwide confront complex and overlapping problems. This includes an imbalance of power with doctors, the hierarchy among themselves, a shortage of nurses and a lack of public recognition. This cluster of inhibiting barriers could create a disempowering environment at the ward, hospital and community levels. As a result their health promotion role might indeed be restricted. It is unwise to deal with these contributing factors separately given their net impact on the development of nurses' role in health promotion. There is a need to "glue" them together and analyze the possible consequences.

The model of person environment misfit is of relevance to the above situation (French and Khan, 1962). It has widely been used to explain organisational environment and employees' performance (Ross et al, 2005). The model describes how the environment and an employee's performance are associated. For example, burn out and emigration occurs when hospital staff's expectations (e.g. reasonable patient: nurse ratio) are not fulfilled by the social environment of the organisation. Nurses might feel more empowered when their leaders are open to ideas and give them positive criticism (Mok and Au-Yeung, 2001). However, in the light of the above model and the challenges hospital nurses face (see the above), maladjustment to the current situation could take two forms. Nurses might upgrade their performance to deal with a stressful working environment related to a certain problem (e.g. working harder to compensate for the lack of nursing staff and supervising newly qualified nurses). This in its own right is unhealthy as it is associated with increased stress levels among nurses and thus maximises the possibility of making nursing errors (e.g. giving the wrong medication) (Aiken, et al, 2002). Conversely, nurses might alter the situation by lowering their performance and use certain coping mechanisms as discussed in the following section.

11.7.1 Resisting and Coping Mechanisms Among Hospital Nurses

Whilst emigration to other countries might be viewed as a coping mechanism to a stressful working environment, the question is how other nurses in the organisation might face the person environment misfit paradigm? This question needs to be answered in a balanced way advocating equally the health of nurses and their patients.

Health promotion as a process of enhancing positive health (e.g personality growth) is influenced by the behaviour of those who provide it (Tones and Green, 2004). The widespread effect of the power imbalance ultimately depends on the tension between the degree of power imposed by certain doctors within the organisation and resistance actions expressed by nurses who feel powerless. When nurses are not able to resist, then domination occurs (Gaudine and Beaton, 2002) and is likely to affect their confidence and performance (see above).

Globally, actions of resistance within the organisation involve speaking up, confrontation, reporting to a higher authority and complaining (Penticuff and Walden, 2000, Sleutel 2000, Fry et al, 2002, Tabak and Koprak, 2007). Other researchers found that nurses might educate patients and their families to take actions against medical decisions, approach ethics committees or act without physician's approval (Dawe et al, 2002). However, findings from this thesis propose that these nurses adopt limited and passive resisting behaviours. This includes complaining to other nurses (in the corridors, lifts and coffee rooms and the hospital canteen) and intentionally slowing the performance. For example, taking a longer time to bring back a patient from X-ray department. These actions have been observed over the data collection period. Generally, no evidence was found about confrontation and speaking up to the hospital management. This is surprising and not consistent with what is found in previous research (see above). This might be explained by a number of factors.

Although participants were assured about the confidentiality of this research, they might have felt that the hospital management would be informed if they uncovered their “hidden” resistance mechanisms. Nurses often avoid resisting decisions they do not agree with in order to be respected by the team (Kelly 1998). Their resistance is often met by the resistance of others (Peter et al, 2004) and specifically put down by doctors (Salvage and Smith, 2000). Accordingly, possible resistance actions carried out by nurses might be seen as a threat to the health care system which is largely controlled by medicine. Research shows that nurses have reported scapegoating, defamation and loss of support from other colleagues (Gaudine and Beaton, 2002) as a response to their speaking out. Whilst these issues are reported in high income countries where the health care system could be more developed than that in Jordan, their effects on nurses’ ability to adopt resisting mechanisms cannot be ruled out.

The second explanation might be attributed to the Jordanian’s culture itself. Individuals in a collectivist culture (e.g people live together in groups or tribes-extended family system) often use avoidance and withdrawal (Holt and DeVore 2005) as there is a belief that avoidance would lead to better outcomes (Friedman et al, 2006).

Consequently, these situations of counter-resistance call for solutions to be developed that deal with the passive subjectivity of hospital nurses and focus on the organisational structure. There is a need for nursing culture within the hospital to change from silent to vocal, closure to opening, isolation to connection and from complaint to action (Mitchell and Ferguson-pare, 2002). Without being able to resist, nurses’ values and knowledge risk being suppressed (Peter et al, 2004) and this in turn might have a negative impact on their commitments to health promotion.

In addition to the emigration to other countries, nurses might use power over approach against patients as a coping mechanism (see below). The questionnaire shows that the majority of nurses (86%, n=50) agree or strongly agree that effective communication with patients has a profound impact on health promotion. However, as given in the previous chapters, the communication was largely guided by nurse

expert approach as opposed to partnership. Some nurses in the focus discussions described patients as “*they do not listen*”. In light of current findings, power over approach with patients might take verbal and non verbal forms.

This might inhibit patients’ freedom of making informed choices and express their concern and beliefs without reservations. In other words, nurses might use “power over approach” against patients to exercise what they are lacking in experience. It was argued that nurses could use their knowledge as a way of imposing their power and control (Henderson, 2003, McQueen, 2000). Such an approach represents coercion in interpersonal relationships to control the behaviour of another, possibly resulting in patients’ feeling powerless (Rafael, 1996, Canter, 2001).

In this case, the interaction between nurses and patients might be disempowering and thus health promotion activities operating at socio-economic levels might not be utilised. It can be argued therefore that the power imbalance between doctors and nurses might lead to power over approach being utilized against patients. Whilst the lack of correlative evidence between these issues is recognized, the utilization of such a power approach might be a coping mechanism for those powerless nurses within the organisation. Further research however is needed to systematically examine the patterns of relationships between nurses and patients and identify any aspects of the use of power over approach. The use of power over approach in this research might also be explained by the nature of cases nurses deal with in surgical and medical wards. In this study some nurses in medical wards had better considered the partnership approach during encounters with patients. By contrast surgical nurses were more often using the top down communication approach.

Whilst other reasons such as the lack of knowledge and the availability of time cannot be ruled out, the nature of patients may be worth consideration. Medical patients are often labelled as “experts” given their wide knowledge about their illnesses which might be maximized by frequent visits to hospitals and clinics. On the other hand, surgical patients are likely to be more demanding due to the acute pain (e.g. fractures) and the unfamiliarity with the care environment (Maidwell, 1996). This could add further workload on the nurses’ shoulders and thus power

over approach might be used as a tool to deal with demanding patients. This explanation parallels the work of Alasad and Ahmad (2005) on communication patterns of ICU Jordanian nurses with critically ill patients. It was found that nurses prefer to care for sedated or unconscious patients as they are “*less demanding*”. It seems therefore that further attention needs to be given to the impact of the nature of cases that nurses deal with on their role in health promotion.

In brief, the nature of the hospital nurse’s role in health promotion should be understood within the hierarchy and power context. As power is the ability to secure desired outcomes (Oudshoorn et al, 2007), both the power of nurses and patients could be enhanced by involving them in decision making processes (Patrick and Laschinget 2006). Therefore, the lack of power of hospital patients might be alleviated if they experience the empowering practice of nurses operating to equalize the power imbalance between them and nurses. By contrast, powerlessness faced by hospital nurses in a medically dominated organisation might be alleviated by involving them in decision making at ward and organisation levels.

The lack of power constricts the ethos and ethics of health promotional work which attempts to address inequity and promote meaningful participation at the national level. Health professionals like hospital nurses are urged (Seedhouse, 2004, Tones and Green, 2004) to advocate for those powerless and less privileged people in society. Logically, this is hard to achieve by a powerless group like nurses within the organisation. In this context, urging powerless professionals to empower powerless people is not only disempowering in its own right but also unethical.

11.8 Multiprofessional and Health Promotion Education: Implications for Practice

This section deals with two interconnected educational issues. Multiprofessional and health promotional education. Their relevance to this work together with implications for practice and curriculum development are elaborated below.

11.8.1 Multiprofessional Education

Perhaps multiprofessional education is one effective strategy to address the power imbalance between doctors and nurses as well as gender related issues. Collaborative learning opportunities for nursing and medical students are feasible; this adds value to the learning and increases confidence levels as well as personal development (Tucker et al, 2003). These are potentially important benefits as it was found that many doctors are uncertain about hospital nurses' competence (Batalden et al, 2003).

Thus, multiprofessional education might familiarize other colleagues of nurses' contribution to the care and this in turn may reduce the hierarchical communication and power imbalance between them. Other writers go further to argue that such a type of education makes visible nursing perspectives and encourages comprehension and also help "curtail the inherited privilege of physicians" (Horsburgh et al, 2001). It is claimed that collaborative learning leads to collaborative care (Goble, 2004). Whilst this seems a logical idea (see above), no strong evidence has been found to confirm this. Having stated this, it is argued however that multiprofessional education could foster the acquisition of team working skills, enhance professional working relationships (Tucker et al, 2003) and reduce negative stereotypical images of nursing (Batalden et al, 2003).

In Jordan, multiprofessional education is needed to promote the development of positive attitudes and skills related to collaboration with other health professionals. This needs be characterized by mutual respect and understanding of other professions' roles, responsibilities and competencies (Wahlstrom et al, 1997). Cultural and gender issues might also be integrated in this strategy. Introducing such a strategy through the first year of professional education might allow students (medicine and nursing) to familiarize them at an early stage with other professionals' roles and foster potential collaboration in the future. This strategy might be further enhanced by continuing education when health professionals experience the real complexity involved in practice. Therefore, medical and nursing students will have

both academic and professional socialisation which might maximize multidisciplinary work.

Nevertheless, organisational issues are the main barriers for implementing such an educational strategy (Tucker et al, 2003). Whilst it might be difficult to overcome structural obstacles to implement this strategy in Jordan, effective health promotion depends on collaboration and coordination of a united team (Horsburgh et al, 2001). Consequently, whilst the idea of multiprofessional education might be in its infancy stage in Jordan, it is worth consideration and research in the future.

From a different perspective, it is important to warn that acquiring more knowledge should not create an even greater gap between nurses' professional knowledge and lay people's beliefs and cultural practices than currently exists. That is, health promotion must be adequately informed by theoretical understandings of local explanatory models of disease (Kim-Godwin et al, 2001, Tones and Green, 2004, Seedhouse, 2004, McLennan and Khavarpour 2004). More advanced learning strategies therefore should not fuel the power over and expert led approach against patients.

11.8.2 Health Promotion Education

Nurses' role in health promotion might not only be affected by the shortage of nurses and power imbalance between them and doctors but also by the nature of health promotion education. In the current study it was found that the curriculum focuses on disease prevention and behavioural change as opposed to health promotion addressing socio-economic issues. This is reflected in nurses' perceptions and practice. The competence of health promotion depends on the knowledge and skills offered by the education (Naidoo and Wills, 1998) and thus nurses need to be aware of the underlying knowledge base and values of health promotion. It is argued that nursing students are expected to understand the principles of ethical and effective health promoting interactions (Latter, 1998). These principles need to be taught in a

supportive placement environment (Smith 1995a, Smith et al, 1999) within the context of what problems graduate nurses might face in reality.

However, this might not happen in reality. Education is often supposed to deliver curricula that focus on broad health promotion reform and strategies, it emphasizes disease focus and health education activities (Whitehead, 2002). This might explain why nursing education faces the challenge of moving away from the traditional and mechanistic approach towards an empowerment and partnership philosophy of health promotion (McWilliam et al, 2000). Learning about health promotion however is complex as it occurs in different contexts and groups (Rush, 1997). In Jordan whilst students are encouraged to learn from their experiences with patients, reflection is not clearly integrated into the evaluative process of nursing students (e.g. Reflective practice).

It is argued that reflection is an effective tool to incorporate theory into practice (Barredeo, 2005) and was identified as a method of empowerment approach to health promotion (McWilliam et al, 2000). It might be used to interpret with evidence encounters with patients and their families (reflection on action). This might be maximized by the intervention mapping process (Bartholomew et al, 2001).

The process starts by identifying the problem or the case. The literature needs to be explored to find evidence to support the determinants of the problem. Then, certain activities are implemented and evaluated. Students and hospital nurses therefore can map their health promotional work against the available evidence to maximize its impact.

So doing “not only allows [nurses] to evaluate the efficiency of the [intervention] but also forces them to generate alternatives to practice that are efficient and effective” (Barredeo, 2005, p1). All above might suggest that the development of health promotion education needs not only flexibility to deal with different contexts but also critical thinking. Yet, even if nurses are armed with reflective skills and evidence based practice, the reality might not be ideal. Policy and decision makers have their

own agenda and identify and manage problems differently (Walshe, 2001) and evidence might be discredited (Rychetnik and Wise, 2004).

Using an “evidence based agenda map” could be effective in identifying health promotion goals, the benefits and the negative consequences of not doing it, thus attracting the support needed from the organisation and policy makers (Rychetnik and Wise, 2004). It seems therefore that in order to use evidence based plans and practice, nurses need to collaborate with and convince legislators, administrators and decision analyzers within and outside the organisation about a certain health promotion plan.

The fact is that researchers themselves -including the current author- will not be able to predict or control the way the evidence will be interpreted and taken into practice (Sauerborn et al, 2002). They might however affect the political plans by being involved in policy formulation as a stakeholder or via stakeholder (Tones and Green, 2004). Accordingly, networking especially with decision makers is not only an important issue for hospital nurses to maximize their role in health promotion, but also for Jordanian researchers. Their role is not only to produce evidence but more importantly to ensure that evidence is valued by policy makers and translated into actions.

Therefore, the challenge is not only how to educate and train nurses in health promotion but also how to create a health promoting setting in which they might realize their potential. This is currently constrained by the orientation of health services towards curative measures as opposed to promoting health agendas. In this essence, the reality of the organisation might not be congruent with nurses’ health promotion education. Thus, a radical reform of the organisation itself towards health promotion is worthwhile.

11.9 Moving away from Curative Health Services towards Health Promotion

Vision

This section addresses the way in which the hospital might reform its services and philosophy of care towards health promoting principles. Three different strategies are proposed below:

- 1- Health promoting hospital
- 2- Adopting the idea of clinical micro-system at the ward level.
- 3- Islamising health promotion ideology.

11.9.1 Health Promoting Hospitals

Evidence from this work indicates that the idea of integrating health promotion within the hospital setting was welcomed by all participants (nurses and patients). However, nurses' perceptions of the hospital as a health promoting setting together with their interactions with patients, suggest that the hospital was used purely to deliver curative care. Consequently, the function of the hospital in the light of health promoting hospital movement was limited and revolves around dealing with already ill people. This is incompatible with the argument suggesting that HPH movement might represent a "collective vehicle" for enabling hospital nurses to advocate and implement a wide reaching social and organisational reform (Whitehead, 2005).

In view of the absence of a policy at national and hospital level stressing the importance of the hospital function in health promotion, together with barriers identified in the previous section (e.g. hierarchy among nurses), a key question arises here. That is, how far is it feasible for Jordanian hospital nurses to adjust their role in order to integrate health promotion principles when no priorities are outlined by the hospital management?

Whilst such a question is contextually limited to Jordanian hospitals, it might also be relevant to other countries as internationally the nurses' role in HPH movement has been described as limited (Whitehead, 2005). Whilst the evidence is incomplete

in the current work, it was found that the hospital management does not offer support to health promotion activities (FGDs with nurses, individual interviews with ward supervisors) and this affected the supportive environment needed at the ward level.

Similarly, a documentary review (e.g. health policies, nursing philosophy) revealed that the role of the hospital is traditionally guided by curative medicine approach as opposed to a positive health approach operating at the organisational and local community levels. It is worth noting that such documents (e.g. nurses' job descriptions) in the hospital have not been updated for about a decade despite the increasing modern literature in health promotion. It is recognized here that the overall hospital management attitudes towards health promotion in general and specifically nurses' role in health promotion has not been examined. It is however worth considering findings of relevance to the overall climate in which the implementation of the health promoting hospital ideal might be shaped. That is, there is a need for empirical indicators that might foster or inhibit such a movement.

The lack of the hospital's support to health promotion has been validated by responses from the manager of training and development as well as ward nurses. This involved a lack of resources focusing on health promotion and training in this area. Indeed, limited attention is given to health promotion in the hospital's policies and nurses' job descriptions. Whilst evidence is limited, the lack of clear commitment (e.g. specific fund) of the hospital to health promotion and related movements might be illuminated by twin factors. Firstly, the hospital managers might not be cognizant of the ideology of such a movement and its positive outcomes on staff and society. Given the marginalization of HPH ideology in the hospital policy as well as nurses' job description, health promotion activities might be difficult to introduce in the daily working of the hospital and as a result necessary funds and personnel might not be provided (Guo et al, 2007). Therefore, building and upgrading organisational capacity for health promotion needs to be put in the heart of health policy agenda and then a continued evaluation is needed to draw indicators of success or failure.

The second reason for little attention given to health promotion within the hospital setting might be related to the way in which the hospital deals with realities and prioritizes their agendas, that is, coping with the lack of financial resources. Currently many Jordanian hospitals give significant attention to medical excellence and advanced surgical interventions in order to attract private patients especially from Gulf countries. Newspapers and TV advertisements are key marketing strategies for the non emergency and elective surgical services and therefore generate income.

This is applicable to the hospital where the study was undertaken. It could be speculated that the managerial staff's lack of interest in health promotion may be because it does not attract immediate hospital revenue and thus managerial staff neglect it when planning the operational workings of the hospital. This explanation reinforces other scholars concerns (Guo et al, 2007) that the allocation of funds to medical services can provide more economic gain and could be given more priority by the hospital management.

Likewise, whilst privatizing the whole hospital, some wards or units could maximize revenue gain. Health economists argue that such an approach by its nature is likely to prioritize curative care over public health and health promotion (McPake et al, 2002). The current fund for the hospital where the study was undertaken is allocated by the Ministry Of Health (MOH). The budgetary mechanisms therefore need to be offered and monitored by the MOH to ensure that health promotion is given resources for its development and continuity and not ignored when the hospital's agenda is set out.

Any budgetary mechanisms however need to consider the organisational culture as the reality is much more complex than offering resources. Related to this, doctors' dominance of decision making positions in the hospital might lead to a limited fund given to nurses' health promotion activities and their training opportunities. In other words, doctors might have the "lion's share" of the fund. Thus, the MOH needs to be aware of what is "going on" in the organisation and not to assume that offering

adequate fund to the hospital would automatically enhance nurses' role in health promotion. Thus, communication and negotiation are needed with all health professions and not only those in authority positions.

Raising organisational awareness of the genuine benefits of health promotion is needed given its diverse benefits. Health promotion within the hospital setting could lead to a decrease in risk factors of disease and improvement in the quality of life of patients and community (Tones and Green, 2004) and minimize the need of costly and avoidable hospitalization. It could also enhance the effect of curative services and heighten the reputation of the hospital and thus bring the economic returns desired by hospital management (Shu, 2004). Other researchers go further to argue that having already developed a relationship with patients in a crisis situation, health promotion might become a marketing communication strategy in which investments might take place within the hospital (Groene and Garcia-Barbero, 2005).

Debatably hospital managers themselves may need to be persuaded by the MOH about the national benefits of the health promotion ideology and thus it could be integrated into their agenda (Guo et al, 2007). In this respect, it seems that nurses' role in health promotion is unlikely to achieve its goals until the hospital management itself is convinced about it. Much of the success eventually lies in the understanding of the organisation as a whole and that health promotion activities might ease rather than add to any organisational reform burden (Auamkul et al, 2003). The hospital managerial staff needs therefore to maximize the active (e.g. involving them in decision making processes) rather than passive participation of staff and patients and establish links with the local community in order to meet health needs in different circumstances.

Related to the above, the current economic crisis in Jordan following the recent Iraqi war has affected both the physical and mental health of Jordanian people. This is mirrored in this study revealing that some patients were more concerned about economic issues than medical treatment. The future health plan in Jordan needs to be re-orientated to emphasize promotive and preventative actions as well as adaptive

measures to save the overall health expenditure. However, if the hospital is to broaden its role in health promotion and operate at a local and national level, it is vital to create an empowering environment for its staff. As shown in chapter 10, nurses' role in health promotion is constrained by medical and managerial hierarchies and indeed sometimes by patients. Therefore, any future strategy to achieve a HPH idea should be based on the notion that the hospital in its own right is a community of both patients and staff. As argued by Tones and Green, (2004), the hospital's concern is to empower not only patients but also staff.

The achievement of personal and organisational goals is strengthened through empowering individuals in the workplace. Powerless people are more rigid, rule minded and less committed to the achievement of the organisational vision (Ellefsen and Hamilton, 2000). Whilst hierarchical organisations fostered more management control, flatter organisational structures strengthened influence and control at the ground level (Ellefsen and Hamilton, 2000). That is, a management style that encourages staff involvement in decision making could enhance organisational satisfaction (Stordeur and Dhoore, 2006). Thus, until the hospital is a healthy environment and has addressed the health needs of patients, their families and staff, it is more challenging to meet the health needs of the local community. In other words, as expressed in some hospitals there is a need to "get our own house in order" (Johnson and Baum, 2001, p, 285). Taking this argument further, if both hospital nurses and the HPH movement are to move beyond the situation where they exist as "an idealism that sounds good in theory" (Cullen, 2002, p, 42), a concentrated examination of the organisational climate is needed. This work highlights some factors which might contribute to better understanding of such a climate and thus might be taken into account when the hospital function in health promotion is to be examined.

It is argued (Rafael, 1999, Whitehead, 2005) that nurses are largely responsible for re-orientating the health service towards a health promotion vision within the hospital setting. This thesis however disputes such a postulation. Of course, hospital nurses' role in reforming the hospital from a disease orientated focus to a positive

health vision cannot be underestimated. Nevertheless, keeping factors that might interplay with nurses' role in health promotion in mind (e.g. medical domination, lack of power), delegating the mission of health promotion to specific department or staff is a feeble strategy. If the implementation of health promotion principles is restricted to certain staff, health promotion activity would remain marginalized and unlikely to challenge the whole organisation to re-orientate its function in the community (Johnson and Baum, 2001).

Indeed, other staff (e.g. doctors, physiotherapists) might sum up their attitudes as "health promotion is not our job". The hospital needs to develop its entire staff to move away from a focus on medicalized sub-specialization to an increasing understanding of the wider health agenda (Wright et al, 2002) and thus improve the overall health of the community. More specifically, if hospital nurses are willing to be involved in the HPH movement which is a part of necessary commitment to "seamless" health care provision (Groene et al 2005), multidisciplinary work across departments and units is not secondary but primary. Therefore expecting hospital nurses to reform the organisation towards health promotion is not only unrealistic but also against the ideology of HPH focusing on the teamwork of health professions as well as lay people.

11.9.2 Adopting the Idea of Clinical Micro-system at the Ward Level

Reforming the whole organisation in Jordan towards health promotion might be problematic due to the lack of funds and personnel. These barriers have been identified in this work and have hindered the development of HPH in high income countries (Whitehead, 2005). In such countries (e.g. France), barriers were tackled by increasing the fund for the HPH movement (Pelikan, et al, 2001). By contrast, Jordan as a low income country has limited resources and thus having an allocated fund for HPH might not be possible. Perhaps an effective strategy to tackle the lack of resources is through breaking things down into more manageable reform.

Findings from this work are derived from surgical and medical wards and thus might serve as the focus for broader organisational reform through focusing on the ideology

of health promoting wards (Coakley, 1998). This author (Coakley, 1998) argues that focusing on the ward setting could facilitate a wider public health role. What is interesting here is that the diabetic nurses in association with the doctors were more effectively engaged in health promotion.

The clinical micro-system idea is applicable to this situation. It is defined as small groups of professionals who can work together on a regular basis to provide care to discrete sub-populations of patients and may be seen as essential building blocks of the health care system (Batalden et al, 2003). Hospital nurses therefore might attempt first to adopt the idea of health promoting ward and then through learning from failure and success at the ward level, the whole organisation might be re-orientated towards health promotion.

11.9.3 Islamising Health Promotion Ideology

Whilst many scholars urge nurses to utilize health promotion models and theories in practice (Whitehead, 2000, Seedhouse, 2004, Ewles and Simnett, 2004, Tones and Green, 2004) equally importantly it might be useful if the attention is extended to organisational and sociological theories and models. Arguably, these issues go hand in hand with the ideology of health promotion (e.g. the model of environment misfit) One serious question however is unanswered. That is, the extent to which health promotion models found in the literature are applicable to Middle East cultures in general and in particular to the Jordanian health care system.

As Suliman (2001) warns, western organisational ideas should not be applied in package forms rather than being adapted to the local environment and culture. The author argues that some of these ideas reported in the seventies are widely used in the Middle East. For example, the link between punishment and productivity is always valued with little attention given to employees' learning issues (e.g. lack of competence). It is argued that the organisational environment is shaped by values and beliefs (Ali, 1996). As a result, the local organisational structure and values are part of the culture and cannot be applied without cultural sensitivity (Higgins and Learn, 1999, Kim-Godwin et al, 2001, McLennan and Khavarpour 2004). Therefore

in order to place the evidence from this study about nurses' role in health promotion within the context of the international literature, a conceptual model is justified and devised in the next sections.

11.9.3.1 The development of a conceptual model for hospital nurses' role in health promotion in Jordan

1- The justification of the model

To date, the literature offers many health promotion/health education models but their effectiveness as well as cultural sensitivity is open to debate. This includes health behaviour and social cognitive models such as the health belief model, (Becker, 1974) the stages of change model (Prochaska and DiClemente, 19984), health action model (Tones 1987), the theory of reasoned action (Ajzen and Fishbein, 1980), Pender's (1987) health promotion model and the KwaZulu-Natal health promotion model (Leana et al, 2004).

These models are developmentally based in health belief and social cognitive models (Parker et al, 2004). Disease focus, fear and behavioural control are the elements of many such models (e.g. health belief model) which contribute to traditional health promotion. Such an approach is practically ineffective and ethically questioned (Robison and Elliott, 2000) and lacks a community based context (Parker et al, 2004). Indeed, the available models tend to be abstract and academic creating a challenge for a health organisation to implement, which culturally might not be accepted by the local community.

Although medical, social and biopsychosocial models of health might contribute to the development of wide-reaching health promotion activities (Whitelaw et al, 1997, Whitelaw et al, 2001), they were largely generated and tested within the western paradigm of health (Pender, 1996, Tones, 2001, Seedhouse, 2004). More specifically, given the fact that religion is a way of life for Muslim patients as shown

in this study (e.g. praying and reciting Quran), the current models might not fully and specifically meet their needs (Rassool, 2000). Yet, it is argued that health promotion is more effective when it is informed by local traditions and beliefs (Mitterlmark, 2007). Religion in the west often does not have a wide impact on people's daily lives, as is the case for followers of Islam (Rassol, 2000). Thus, health care professionals may need to acknowledge the importance of integrating patients' beliefs into the framework of health promotion agenda. Internationally, however, nurses feel that caring for patients of Islamic denomination present them with professional difficulties due to their own religious beliefs and practices (Halligan, 2006).

Taking the above arguments together, it can be concluded that there are concerns that the existing models and theories of health promotion might not fit with other health care systems, specifically in Jordan. In fact, adopting such theories and models when they are used in isolation from a suitable setting and context could lead to a reinforcement of a traditional health education paradigm (Piper and Brown, 1998).

It is not surprising therefore that Nutbeam, (1999) argues that in order to deliver effective health promotion, one must develop a model/framework that suits a certain health care setting and is underpinned by relevant theoretical constructs. Conceptual models provide the most comprehensive and holistic approach to health promotion in a certain context (Nutbeam, 1999). That is, health promotion is not only judged on its actions but also on its commitment to the development of a suitable agenda and frameworks (Whitelaw, 1997).

2- The Theoretical Drivers of The Model

Some theoretical drivers of health promotion within the Islamic context are given below to guide the development of the conceptual model. These drivers are explored at the levels of community, organisation and individuals. Whilst these levels are closely interrelated, for the sake of clarity they are discussed separately.

2.1 . The theoretical driver at the level of organisation and community

Structural and organisational changes are central issues in the Islamic ideology and they could pose real opportunities for nurses to build healthy public policies (Farrell, 2003). For example, “Ummah” refers to the belief that humankind should live as one unified society, not separated by ethnicity, religion and nationality (Hasnain, 2005). This belief is in line with modern health promotion principles embracing equity and social justice (Tones and Green, 2004, Seedhouse, 2004) and could be considered as a springboard from which nurses’ role in health promotion is reformed (De Leeuw and Hussein, 1999).

In line with this reform, radical change in the health organisation might be better implemented when its bases are congruent with values in the cultural context. For example, in Morocco a successful implementation of total quality management occurred by associating it with Islamic norms and values (Gelfand et al, 2007). Likewise, it might be more effective if nurses’ role in health promotion and health promoting hospitals in Jordan is guided by an Islamic management approach. Such an approach is driven by issues of equity, justice, teamwork, mutual respect, dialogue and rationalised actions (Ali, 1996).

These values are detailed in the Islamic scriptures and supported by western ideology of organisational development (Hasnain, 2005) but often violated in practice within Arab organisations in which decisions might lack effectiveness due to the lack of planning (De Leeuw and Hussein, 1999). However, patients in this work stressed the fact that Islamic values and daily lifestyle are inseparable but often not well considered by nurses as shown at the beginning of the chapter (Spiritual care).

At the community level, examples of successful health promotion which involves religious leaders in Muslim society are well documented. In Uganda and Senegal, 3000 Muslim leaders were educated on how to prevent and reduce the risk of HIV within their communities (Kagimu et al, 1998). Education was associated with

Islamic beliefs such as not protecting your health is a sin. It was found that individuals were more willing to take part in the education sessions associated with such Islamic beliefs. Whilst the complexity of preventing such a disease is valued, the study also points out that promoting health in general might be more effective when it is informed by values that are highly respected by the community.

In Islam, “Zakat” means that our wealthy people need to consider the poor in the society and wealth is from Allah (Hasnain, 2005). Each financially capable Muslim needs to pay every year a portion of money to the poor. This provides guidelines for the provision of social justice, positive healthy behaviour and an equitable socio-economic system (Rassol, 2000). This is an important issue as the lack of financial resources was identified by patients as a key factor to enhance their health.

2.2 The theoretical drivers at the level of individual and family

Family involvement in planning care is crucial for patients in Muslim countries (Halligan, 2006). In line with evidence from this Jordanian study, it was found that strong family support was a key issue that affected Muslim patients' health in Saudi Arabia (Nahas, 1999) and particularly older people (Alshareef, 2005).

Islam teaches that our healthy body is a gift from God, we should not misuse it and we need to give it the best care and nutrition (Rassol, 2000). Evidence has shown that Islam has a positive impact on women's health behaviours in respect of breast feeding and birth spacing, diet and non-consumption of alcohol and cigarettes (Youssef 1999). Thus, Islam and the concept of health promotion share some similar principles that advocate a better life. This includes exercise, good nutrition, adequate rest, mental calmness, cleanliness, tranquillity of family life and sexual health (Rassol, 2000). These are reported in the international literature but are more valued and welcomed by people when they are placed within a religious framework (Razali et al, 1998, Matthews et al, 1998, Oman et al, 2002 Hjelm et al, 2005).

However, whilst empowering hospital patients to adopt healthy lifestyle behaviours needs to be encouraged by hospital nurses, Islam urges health professionals in general to provide care to all patients regardless of their religions and life style practices. That is, at the individual level, Islam does not look at the beliefs of sufferers and their ethnic background and social status (Rassol, 2000). To provide culturally sensitive health promotion activities, it is important to remember that each individual is unique in terms of expectations and beliefs and thus nurses need to identify such elements in advance (Yoho and Ezeobele, 2002).

In summary, integrating hospital nurses' role in health promotion within existing social, cultural and genuine religious ideology and working with religious leaders as key collaborators could be the first step on the ladder of enhancing the health of both hospital staff and the local community, as stressed by WHO's declarations (WHO, 1997). Islamizing the role of hospital nurses' role in health promotion needs to encapsulate both individualised and community based approaches using faith-based interventions that are driven by a collaborative synergy among religious leaders as well as the community. However, it is essential to ensure that a faith based model is flexible to address needs of other faiths. The flexibility of the model is judged by the ability to deal with the diverse population and by its social acceptability (Whitelaw et al, 1997). Currently, Jordan is largely dominated by Muslims (95%, Christians 5%) and thus the faith based model/framework of health promotion needs to adjust its components to the cultural and religious needs of certain groups. For example, Islamic dietary law, family ties and kinship, health and religious activities (fasting and obesity, praying and exercise) need to be incorporated in the model proposed in the next section. However, in the light of the diverse factors interplaying with the development of nurses' role in health promotion explored in this thesis, realistically, it seems that such a task is complex to achieve. On this basis, the core factors at the heart of the development of the conceptual model are identified in the next section.

3- The Conceptual Model About Hospital Nurses' Role in Health Promotion in Jordan

In this thesis, factors affecting the development of nurses' role in health promotion operate at different levels, that is, at the level of individual, organisation and the Jordanian community. Thus, the proposed model emphasises the development of health promotion with other sectors that affect the overall health of the community. In line with the Vienna recommendations concerning the health promoting hospital, health promotion should be delivered in conjunction with existing governments and health services in the community (WHO, 1997).

The development of the model is driven by a subtle realist approach which is driven by the constructivist epistemology as opposed to the predetermined objective truth about hospital nurses' role in health promotion and related factors. Instead, the model is guided by the findings of the thesis which are confirmed by the international literature of health promotion. Whilst the factors that affect the development of hospital nurses' role in health promotion are closely interrelated, they are organised into the following levels of influence: micro-, meso, and macro.

The micro level (Intrapersonal/Individual at the ward level) includes knowledge, beliefs and the interaction between nurses and their patients. Interpersonal factors include the family and social connections. The meso level includes the organisational structure (the workplace). The level of the community, which involves the link to the organisation and national policies, is referred to in the proposed model as "macro level".

These levels are not only validated by findings from the study but also by the notion arguing that the health care system is a cultural system. More specifically it is reinforced by Kleinman's (1978) model into the health care system components. These include three social arenas within which health is experienced, shaped and reacted. These are popular, professional and folk. The popular, as reported in health promotion literature (Tones and Green, 2004), includes the family context of health

and illness. The folk is related to traditional curing of illness as outlined in this thesis (e.g. using herbs and local healers), and finally the professional involves specifically nurses in the health care system and their broader links to the community. In summary, the proposed model has a micro level (individual focus), meso level (organisational focus) and macro level (population focus) (See Diagram 1).

By using these levels and understanding how they affect each other, nurses and other health professionals can draw on what individual, social and organisational factors influence nurses' role in health promotion and thus affect patients' health gain. The model therefore is multi-level and addresses diverse issues.

Although informed by evidence from this study and international literature it differs from those models described earlier in that they do not incorporate all factors that interplay with nurses' role in health promotion together with strategies to tackle related barriers in a certain cultural setting.

The major models of health promotion deal with specific knowledge, tasks and activities in formulating strategies for intervention, but they fail to address the factors that interplay with planning and evaluation of health promotion work.

The model illuminates the complexity of the hospital nurses' role in health promotion taking into account related challenges. However, whilst nurses have a potential role in health promotion, they represent only a spike in the wheel of the whole model. That is, given the macro factors affecting the development of such a role, health promotion activity is a dynamic and co-operative process that requires key players to foster and maintain its success. The involvement of patients and their families, nurses and the community, as well as other health organisations and religious leaders is vital.

The model might enable cross-cultural comparisons to be made about hospital nurses' role in health promotion. As a result, educators and decision makers worldwide might be better prepared to plan and deliver culturally suitable educational programs matching the needs of a diverse population. However, having stated this, no claims are made here to indicate that the model is a quick fix to

overcome barriers to nurses' role in health promotion in any hospital. This is due to the differences in the nature of the health care system itself, the existing resources and training opportunities for hospital staff. It should be noted that conceptual models differ from theory in that they are not usually concerned with resolving global problems, but addressing a specific issue within a certain context (Earp and Ennett, 1991).

The model therefore could be considered as a springboard for developing a theory in health promotion specifically related to health care systems in Muslim countries. However, such development cannot be pressure-cooked. Instead "it presumes a cultural infrastructure that takes time to grow" (Hofstede, 1993, p 86). Many health promotion activities fail to achieve their goals due to unidentified contributing factors and overlapping issues (Tones and Green, 2004, Whitehead, 2003,a). This conceptual model has attempted to overcome such problems and it is hoped would raise awareness of the complexity of nurse's role in health promotion within the hospital setting. Understanding the complexity of hospital nurses' role in health promotion as illuminated by the model might increase the likelihood of targeting multiple factors that inhibit the development of such a role. However, future empirical work needs to test the model and examine how addressing different contributing factors might foster nurses' role in health promotion within the hospital.

Diagram 1: The conceptual model about nurses' role in health promotion in Jordan

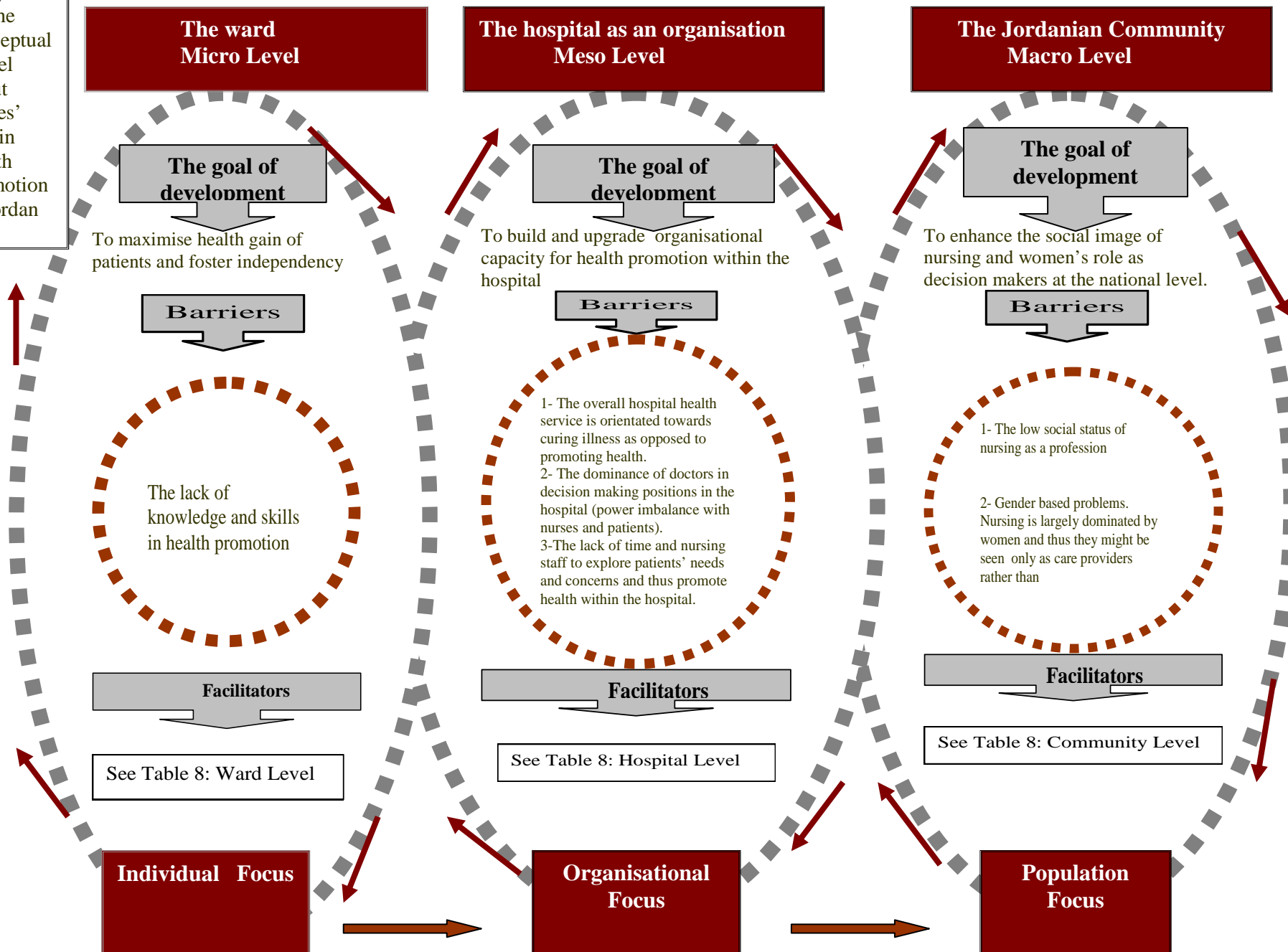


Table 8: Facilitators to achieve the model goals and address barriers outlined in Diagram 1.

The Level	Facilitators
Ward Level	<p>1- Different approaches need to be utilised at the micro level with patients. Medical and behavioural approaches focus on individuals' lifestyle practice need to be associated with Islamic values and principles such as damaging your health is a sin.</p> <p>2- Adopting healthy lifestyle behaviours might be better discussed to Muslim patients as part of the Islamic doctrine. This includes exercise, good nutrition, adequate rest, mental calmness, tranquillity of family life and sexual health.</p> <p>3- The link between religious practices (e.g. fasting and obesity, praying and exercise) need to be linked with health promotion idea.</p> <p>4- Health promotion in general needs to specifically address the religious and cultural needs of all patients and the local community (culturally competent health promotion activities).</p> <p>5-Using cultural communication skills might maximise patients' receptivity to nurses' role in health promotion. This needs to be informed by partnership, shared agenda and empowering approach as opposed to an authoritative and expert led approach.</p> <p>6- Nursing curriculum needs to integrate health promotion courses at early stages of students' education. Components such as health policy, Islamic beliefs and health, poverty, ethics of health promotion and reflective practice need be incorporated in the curriculum.</p> <p>7- Continued education is needed after qualification in order to keep nurses up to date with recent literature and challenges in health promotion.</p> <p>8- Ensuring the suitability of the clinical placement for nursing students as well as the availability of role models in health promotion</p>
Hospital Level	<p>1- The capacity of health promotion needs to be put in the heart of health policy agenda of the hospital. Such a capacity needs to be guided explicitly by Islamic values such as equity, justice, team work, mutual respect, dialogue and rationalised actions. This might foster the acceptance of new development and thus change.</p> <p>2- A certain fund for health promotion needs to be offered and monitored by the MOH to ensure that health promotion is given resources for its development and continuity.</p> <p>3- Raising organisational awareness of the genuine benefits of health promotion.</p> <p>4- Brainstorm meetings need to be undertaken with all staff (e.g. doctors, nurses, domestics, catering staff), local community (Muslim, Christian leaders), the Ministry Of Health, Nursing Council and non-governmental agencies. These meetings might help in shifting hospital curative services towards a more health promoting setting ideology.</p> <p>5-Nurses' job description as well as the philosophy of care should be updated with an explicit focus on their role in promoting the health of patients and their families as well as the local community.</p> <p>6- Understanding the reasons of why nurses emigrate to other countries and addressing them by the hospital's management. Also, what "receiving hospitals" offer for nurses needs to be identified.</p> <p>7- Improving the pay rate of nurses which might in turn enhance retention rate.</p> <p>8- Improving the working climate by recognising nurses' contribution to care and adopting a more democratic and less hierarchical nursing leadership.</p>
Community Level	<p>1- Utilising the media by nurses in Jordan in raising awareness of nurses' knowledge and skills and how these might contribute to healthier community. TV drama might be an effective method to achieve that.</p> <p>2- Negative image of nursing is an international problem and thus Jordanian nurses might be better addressing this problem by networking with other colleagues in other countries, with health service providers (liaison services) and other stakeholders in the community.</p> <p>3-Nurses as well as other health care providers need to acknowledge gender relations together with roles involved in the society and organisation. Meaningful change at both organisational and national level requires both genders to work hand in hand to achieve their ambition and social status.</p> <p>4- Effective networking with the Ministry of Media and Communication, the Minister of Health in Jordan and importantly Nursing Council. Doing so might ensure that nursing should not be excluded from the decision making process because it is dominated by women.</p> <p>5- Nurses as well as other health care providers need to acknowledge gender relations together with roles involved in the society and organisation. Meaningful change at both organisational and national level requires both genders to work hand in hand to achieve their ambition and social status.</p>

11.10 Conclusion of the Discussion

Primarily, this chapter offered insights into how the overall climate within the organisation might shape the role of nurses in promoting patients' health. It contributes to the body of knowledge in this largely unexplored area, but it is impossible to capture comprehensively the complexity involved in organisational behaviour and its impact on health promotional processes.

It is argued however that health promotion research in hospitals might be used as a vehicle towards a broader aim of development within the organisational setting (Whitelaw et al, 2001). That is, the current work might pave the way for future research focusing on how health professionals in Jordan can strive to achieve a "seamless" service that views the hospital as an integral part of its surrounding community and thus a valuable tool for establishing, adjusting and evaluating public health policy.

It can be concluded that there is a need for a radical reform strategy focusing on the social-political empowerment of the hospital employees and clients. Power, cultural and gender issues need to be incorporated into the framework of such reform. However, radical reform from curative orientated services to a more holistic health agenda operating at the socio-economic and political levels is not possible without serious organisational commitment to the reassessment of the hospital's current role, social status and functional and physical suitability. This could be achieved in many ways such as brainstorming meetings with all staff (e.g doctors, nurses, domestics, catering staff), local community (Muslim and Christian leaders), the Ministry of Health, the Nursing Council and non-governmental agencies. The whole process could be informed by the recent debate in health promotion as well as recommendations put forward in this thesis.

This chapter cannot be concluded without placing its contribution within the context of the current nursing health promotion debate. The review of literature reveals that nurses are often urged to take a leading role in health promotion. Whitehead (2003,b)

goes further to argue that nurses must accept the blame for failing to take such a leading role given their large numbers. Unfortunately whilst nurses may work in hospitals in large numbers, their power base and thus capacity to make changes is indeed limited. In congruence with evidence from this thesis, it has been suggested that hospitals in Jordan place nurses in a subordinate position to administrators and physicians (Mrayyan, 2004, Oweis, 2005). Likewise, increased use of technology is the area where nurses lack influence (Smith and Cusack, 2006).

Taking these findings together and moving the debate forward, it seems that it is unwise to expect nurses to reform the health system from a disease to a health promotion focus at a time when their own power base is limited and their social status is low in many countries. Associating nurses' ability to promote the health of people because of their large number should be taken with care. Doing so is misleading and oversimplifying the complexity of the nurses' role in health promotion and the issues involved. The power imbalance between nurses and doctors, the hierarchy among nurses themselves, the power based gender problem and the public's image of nursing perhaps are more powerful elements in shaping hospital nurses' role in health promotion than their numbers.

To conclude this chapter, organisational change is a complex task and change can only be achieved when a certain working climate changes as well. Realistically, this cannot occur overnight and as Robinson and Hill (1995) suggest "miracles take a little longer". Eventually, taking a little longer to reform the organisation is better than not reforming it. The thesis proposed a conceptual model about nurses' role in health promotion that might help to achieve such an organisational reform. However, the study raised more questions than were answered and thus it might be used as a springboard from which future research is developed. Researchers are urged to extend their attention and address the different points summarised in table (9).

Table (9): Recommendations for Future Research

1- This study has focused only on one hospital. Consequently, there is a need to replicate the study in other hospitals to sharpen its external validity. Similarities and differences in the nurses' role in health promotion can be outlined.

2- Hospital nurses do not work in isolation. How other health professions (e.g. doctors, physiotherapists) advocate and perceive nurses' role in health promotion requires investigation.

3- Hospital patients are often accompanied by many relatives. The extent to which nurses pay attention to the family-based approach of health promotion could be explored.

4- Further research is needed to systematically examine the patterns of relationships between nurses and patients and identify any aspects of the use of power over approach. The characteristics of those against whom power over approach is used needs to be fully identified (e.g. elderly, illiterate, mentally and physically disabled patients).

5-- Jordanian' attitudes toward nursing as a profession and the hospital nurses' role in promoting health in general needs to be examined. This might be addressed by a national survey research.

6- Finally, the transitional stage from "being a student nurse" to "being a qualified nurse" and how this might affect their views towards health promotion is worth examination. This might be better addressed by a longitudinal study. Participants' views and experiences could be monitored over a period of time.

Chapter Twelve: Conclusion of the Thesis

In this thesis, the current researcher attempted to take up the recent worldwide challenge to address empirically health promotion issues within a certain health organisation (Mittelmark, 2007). Specifically, using a single case study design and methods triangulation strategy, the study examined Jordanian hospital nurses' role in health promotion together with contributing factors involved.

Whilst there are some good examples of health promotion, generally hospital nurses have not yet developed their knowledge and skill base in health promotion beyond educational and medical approaches aimed at changing individuals' lifestyles practices. Therefore the way their role is perceived and operationalised in practice is incompatible with recent health promotion encapsulating empowerment, advocacy and political actions.

The study identified key instrumental factors that might shape nurses' role in health promotion. This includes the imbalance in power between doctors, nurses' and patients and the lack of time. Indeed, the nature of nursing education was found to be a contributing element to the limited progress hospital nurses made in health promotion.

The thesis nevertheless does not claim causality as this is not only unrealistic but also beyond its aim and methodology. The availability of time, resources and adequate nursing staff does not necessarily guarantee the delivery of health promotion. Simply, it would be naive to conclude that offering X in the future will produce Y in an uncontrolled and hierarchical organisational structure where diverse factors affect individuals' attitudes and decisions.

However, evidence from this work indicates that the identified barriers might hinder the development of hospital nurses' role in health promotion and constrain its impact. These barriers need to be addressed at ward, organisation and the national level. Despite the limitations of this work, its findings together with previous research

indicate that there are much more complex issues to consider when hospital nurses' role in health promotion is to be understood. That is nurses' role in health promotion should not be decontextualised.

Unquestionably, moving a limited resource hospital like the one analyzed in this work towards a more health promoting system is a difficult task. Endeavour requires not only initial and short term commitments and passion but also continued and concentrated efforts to reach this end. Therefore overnight organisational "rush" reform together with a "quick fix" approach is indeed impractical and underestimates the sophistication of the world of organisation culture. In fact, this in its own right might be disempowering for staff due to the lack of adequate analysis of the situation. What is argued here is that moving away from curative services towards promoting health agenda is a whole process that needs reflection, continued monitoring and patience.

This type of reform needs serious commitments from clinical and educational bodies to support it and put in place the mechanisms to ensure its success. To accommodate this reform, hospital nurses need to be encouraged to develop greater sense of local community and how their organisation fits in with the surrounding locality where they might practice (Whitehead, 2003). Accordingly, intersectoral and multidisciplinary work is needed, and indeed as one nurse in this study stated, "one hand does not clap" illuminating the need for more joint thinking and acting.

Exploring the policy reform in Jordan, it was postulated that democratisation is like a palm tree that needs a certain soil and climate to grow up and without such elements you need to expect something else to emerge (Jordanian parliamentary official, February 1993 cited in Curtis and Jillian, 2004). Likewise, this thesis concludes that the role of hospital nurses in health promotion is unlikely to be developed in knowledge and skills and move from rhetoric to reality until the overall climate within the hospital is improved and contributing factors laid out in this thesis are considered.

It is hoped that this thesis offers evidence based implications for incorporating health promotion into nurses' daily practice and stimulating international debate in this area. The proposed conceptual model in this thesis might be considered as a benchmark against which future health promotion work and theories are developed. So doing might enable nurses as well as other health care providers to deliver more effective and ethically sound health promotion activities matching patients' cultural beliefs and expectations.

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Appendix 1: The interview schedule for focus group discussions with hospital nurses

Q1 As staff nurses how do you understand health? Examples?

Q2 What is the main aspect of health you focus on while at work?

Q1 what is your understanding of health promotion?
Experiences and stories...

Q2. How do you see the hospital as a setting for health promotion? explanations?

Q3 Could you please let me know further about the barriers that prevent you from adapting your role in health promotion?

Q4- what do you suggest to make your role in health promotion more effective?
Facilitators?

-----Summary of key issues generated by the discussion-----

Appendix 2: The questionnaire

Please place ☒ in the appropriate box.

{ 1 } – your sex is:

Male-----☐

Female----☐

{ 2 }- How old are you?

-----years

{ 3 }- You work in:

1- Surgical ward-----☐

2- Medical ward.-----☐

3- Other, please specify -----

{ 4 }- The program you have graduated from is:

1- Diploma program (3 years)----☐

2- Degree program (4 years)-----☐

3- Master program----- ☐

4- Others, please specify-----

{ 5 }- How many years have you worked as a registered nurse?

Years () months ()

{ 6 }- Now, I would like to obtain your views about your role in health promotion in the hospital and your understanding of health. Please place ☒ in the appropriate box to indicate the strength of your agreement or disagreement with the following statements.

1- Health is the freedom from illness

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

2- Understanding health holistically is important for effective care.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

3- God controls our health.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

4-Hospital nurses have an important role in promoting patients' health.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

5- In my opinion, hospitals are a suitable place to promote patients' health.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

6- In general I feel that this hospital needs to take more responsibility for promoting patients' health.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

7- I think that health promotion is a waste of time.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

8- Patients who are responsible for damaging their health (e.g. smokers, drug users) should not receive any health promotion.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

9- Therapeutic communication between nurses and patients could have a strong impact on the achievement of health promotion.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

10- I do not carry out health promotion because of the lack of time.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

11- I received good education in health promotion.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

12- Nursing leadership in the hospital is prevailed (controlled) by doctors.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

13- Patients do not accept nurses to promote their health.

Strongly agree ☐ Agree ☐ I can't decide ☐ Disagree ☐ Strongly disagree ☐

14- I feel that it is not possible to promote the health of the opposite sex.

{7}- Do you think that health promotion and health education are the same?

1- Yes ☐

2- No ☐

IF NO, please describe your understanding of their meanings. Please feel free to use English or Arabic language.

Health Promotion: -----

Health Education: -----

*****Please Put The Completed Questionnaire in the Box Provided In Your Ward*****

Thank you so much indeed for your time!!!

Appendix 3: Interview schedule with medical and surgical supervisors

Q1 could you please tell me about the nature of the hospital nurses' role in health promotion?

Probes

- 1- In your opinion, what sorts of health promotion activities carried out by nurses? How are they planned? Who financially support them?
- 2- In general do you think that nurses in this hospital have a potential to promote patients' health? Why? Examples?

Q2 What factors could affect the development of hospital nurses' roles in health promotion?

Probes:

- 1- Any future strategy to overcome them?
What do you suggest to develop hospital nurses' role as health promoters in the future?
- 2- Suggestions? How this might work?
- 3- Do doctors interfere with nursing leadership? How? Examples? Suggestions?

-----Summary of key issues generated by the discussion-----

Appendix 4: Interview schedule with the nursing educator

Q1 Could you please tell me about the nature of nursing health promotion and health education courses?

Probes

- 1- What are their main contents?
- 2- How and where do students undertake their placement?
- 3- How are they evaluated?
- 4- Is there any focus on the hospital setting?
- 5- Is there any future curriculum plan to review such courses?

Q2 Overall, do you think that graduate nurses are capable to promote patients' health within the hospital setting?

Q3 As an educator, what factors could affect the development of hospital nurses' role in health promotion?

Probes

- 1- How do such factors affect such a role? Examples?
- 2- What do you suggest to overcome the barriers that could prevent hospital nurses from translating their health promotion role into practice?

-----Summary of key issues generated by the discussion-----

Appendix 5: Focus group discussion schedule with patients

Part one: patients' conceptual understanding of the concept of health and health promotion. (Brain storm technique + funnel structure of focus group discussions)

Q1 When we talk about health, what does such a word mean to you? In other words, what being healthy means to you as a patient?

(The question will be directed to the whole group, no constant eye to eye contact will be made with a particular participant)

Probes

1- Could you please, give me examples to illuminate this? Who agrees or disagrees with this? Why?

2- Now, is such understanding based on life experience or on another other basis?

3- Has your own understanding of health changed since the time of admission? How and why?

3- In your opinion what the most important aspects of health? Why

4-What do you do when you get ill? Why?

Now we move on to another concept, I would like to discuss with you

Q2 When we talk about health promotion, what does this mean to you?

Probes

1- Could you please give me examples to illumine this? Who agrees or disagrees with this? Why?

2- Now, is such understanding based on life experience, educational background or on another basis?

3- Do you think that health promotion and health education are the same? How?

Part two: the suitability of the hospital setting to promote patients' health and nurses' roles in health promotion.

Q1 In your opinion, do you think that the hospital is a good place for health promotion? Why?

Q2- Generally, who do you think are the most appropriate health professionals to promote your health? Why?

Q3- More specifically, do you think that hospital nurses play an important role in promoting patients' health? How, Why?

-----Summary of key issues generated by the discussion-----

Appendix 6: Participants' information sheet (Questionnaire)



Queen Margaret University
EDINBURGH

I am Noordeen Shogirat- research student from the Nursing School/ Queen Margaret University in Edinburgh/ Scotland. As part of my PhD degree, I am undertaking a research project funded by Muttah University. The title of my project is: “The role of Jordanian hospital nurses in promoting patients’ health”. The project aims to understand hospital nurses’ role in promoting patients’ health. No study has been done in this area in Jordan and thus it is hoped that the study will offer valuable results that could guide the future development of nursing health promotion activities in hospitals.

Sometime ago some registered nurses in this hospital have participated in group discussions and observations in connection with this study aims and following on from this, I am now interested to find out further about hospital nurses’ views towards health promotion. To do so, I am looking for volunteers who work in surgical and medical wards to participate in the study. If you have already taken part in focus group discussion or observation or both, you are also welcome to be involved in this research stage.

If you agree to take part in this study, you are asked to complete the attached questionnaire. The questionnaire includes a set of statements about your own views towards nursing health promotion activities in hospital. It is expected that it will take 12 minutes to be fill in.

Participation in this is entirely voluntary and you can quit at any time without giving a reason. This is an anonymous questionnaire and its data will be analysed in a statistical form and then the results will be presented as group data. This means that your identity will not be revealed at any stage of the research. To achieve this, I

would be grateful if you don't put your name on the questionnaire. If you agree to take the questionnaire, fill it in and return it in the box provided, this will be considered as giving me your **consent** to take part in the study.

Each questionnaire will have a specific number and at the end of the study an incentive of £10 will be given to the randomly selected one. I highly appreciate you for sparing some minutes from your valuable time to complete the questionnaire. The results may be published in a journal at the end of this research.

If you would like to contact an independent person, who knows about the project but not involved in it, you are welcome, to contact Dr Samiha Jarah. Her contact details are given below. If you have read and understood this information sheet, any questions you had have been answered, please now complete the questionnaire and return it in the box provided.

In anticipation, thank you very much for your help

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Appendix 7: Participants' information sheet (focus group discussions with nurses)



Queen Margaret University
EDINBURGH

I am Noordeen Shoaqir- research student from the Nursing School-Queen Margaret University in Edinburgh/ Scotland. As part of my PhD degree, I am undertaking a research project funded by Muttah University. The title of my project is “The role of Jordanian hospital nurses in promoting patients’ health”. The project aims to understand hospital nurses’ role in promoting patients’ health. No study has been done in this area in Jordan and thus it is hoped that the study will offer valuable results that could guide the future development of nursing health promotion activities in hospitals.

The first stage of the research involves arranging separately 4 focus group discussions with registered junior nurses and with senior nurses. Mainly, I want to find out what factors affect health promotion where you work. I am only looking at surgical and medical wards. If you agree to take part in this project, your name will be put on a list with others. In the following couple of days, I will select randomly the participants from the list(e.g. every third person from the list). You will be informed in person if you have been selected.

It is expected that each group discussion will encompass a range of participants between 6 and 12. Before the group discussion, I need to have your signed consent form enclosed with this information sheet. I expect that the discussion will last about 45 minutes to one hour. The discussion will be tape-recorded, so that I can have an accurate record. Tape recordings later will be destroyed and only me and my supervision team will have access to them. Refreshments will be provided during the discussion. Also, I will contact you later to ensure that I have correctly reported your

views. Further details about where the discussions will be held will be given to you later.

Participating in this study is completely voluntary. This means that you can quit at any time without giving any reason. The data will be anonymous as much as possible, but you could be identifiable from tape recordings of your voice. Your name will be replaced with a number and it will not be possible for you to be identified at any stage of reporting the data gathered. At the end of this study, a summary of key results will be given to you if requested. The results may be published in a journal at the end of this research.

If you would like to contact an independent person, who knows about the project but is not involved in it, you are welcome, to contact Dr Samiha Jarah. Her contact details are given below. If you have read and understood this information sheet and any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

In anticipation, thank you very much for your help

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Appendix 8: Participants' information sheet for nurses (observation)



Queen Margaret University
EDINBURGH

I am Noordeen Shogirat- research student from the Nursing School-Queen Margaret University in Edinburgh/ Scotland. As part of my PhD degree, I am undertaking a research project funded by Muttah University. The title of my project is: "The role of Jordanian hospital nurses in promoting patients' health". The project aims to understand hospital nurses' roles in promoting patients' health. No study has been done in this area in Jordan and thus it is hoped that the study will offer valuable results that could guide the future development of nursing health promotion activities in hospitals.

I am interested to undertake some observations in surgical and medical wards. The observation aims to describe nurses' roles in promoting patients' health while they look after them. It also aims to identify difficulties and factors involved in this, in order to help nurses to develop their health promotion role in the future. If you have participated in previous focus group discussions, you are also welcome to be involved in the observation.

The observations will be focusing on discharge interventions, medicine rounds, and any events you consider suitable for planning or delivering health promotion activities. Only those patients who are both physically and psychologically able to communicate will be involved. Also, they need to be hospitalised for at least a week. Before observations are to be undertaken, patients' consent as well as yours will be obtained. Your decision if you decide not to be observed will be respected. With both you and your patient's permission, I will be seated where I can see and hear about

what goes on. Also, I will write some notes about what goes on during different occasions (e.g. discharge interventions).

I may wish to record some of your conversations with patients in order to help me make an accurate record. In addition, at the end of each observation I will make notes about the overall situation I have observed. Thus, I would be grateful if you do not do or say anything different from what you usually do. We can talk about it after the event, if you wish to make certain comments about what has been observed.

I am not evaluating your personal knowledge and skills. Rather I would like to learn from different nurses and interactions about what happens on a regular basis. This could result in improving the overall quality of patients' care as well as supporting the development of nurses' health promotion role.

Taking part in this study is completely voluntary. You may withdraw or change your mind at any time without giving a reason. The data will be anonymised as much as possible, but you could be identifiable from tape recordings of your voice. In this case, your name will be replaced with a number and it will not be possible for you to be identified at any reporting of the data gathered. However, if at any time of the interaction with a patient you feel uncomfortable to record a specific issue, recording will be suspended and with your permission, hand notes will be taken. If either you or your patient decide to cancel the observation while it is in progress, I will do so immediately without any negative impact on your position as a nurse.

All the information will be kept confidentially for the purpose of this research and particularly, no information will be shared with your supervisor. At the end of this study, a summary of key results will be given to you if requested. The results may be published at the end of the research.

If you would like to contact an independent person, who knows about the project but is not involved in it, you are welcome to contact Dr Samiha Jarrah. Her contact details are given below. If you have read and understood this information sheet, any

questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

In anticipation, thank you very much for your help

Noordeen Shoqirat
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Dr Samiha Jarah,
The University of Jordan
Faculty of Nursing
University Road
Amman, PO Box 13046,
Tel: 845 65 841841

Appendix 9 : Participants' information sheet for patients (observation)



Queen Margaret University
EDINBURGH

I am Noordeen Shooqirat- research student from the Nursing School-Queen Margaret University in Edinburgh/ Scotland. As part of my research, funded by Muttah University. I am looking at trying to understand hospital nurses' role in promoting patients' health. No study has been done in this area in Jordan and thus it is hoped that the study will help nurses to offer you better care.

I am interested in seeing what happens in hospital regarding the nurses' role in promoting your health. I will be focussing on medicine rounds, where the nurse is giving advice or when are you due to go home. In order to take part in this study, you need to be in the hospital for at least a week, so that I can meet you in person a day before the observation takes place. During this time also we can talk about the research and I can answer your questions about it. With both you and your nurse's permission, I will be seated where I can see and hear what goes on. I may also wish to tape record and make notes about what goes on.

Taking part in this study is completely your choice. You may withdraw at any time without giving a reason. You can stop the recording at any time once it is started without any effect on your care. Your name will be replaced by a number and no one will be able to identify you in the report. All the information will be kept confidentially for the purpose of this research. The results may be published at the end of the research.

If you would like to contact an independent person, who knows about the project but is not involved in it, you are welcome, to contact Dr Samiha Jarrah. Her contact

details are given below. If you have read and understood this information sheet, and any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

In anticipation, thank you very much for your help

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Appendix 10: Participants' information sheet (focus group discussions with Patients)



Queen Margaret University
EDINBURGH

I am Noordeen Shogirat- research student from the Nursing School-Queen Margaret University in Edinburgh/ Scotland. As part of my research, funded by Muttah University, I am looking at trying to understand hospital nurses' role in promoting patients' health. No study has been done in this area in Jordan and thus it is hoped that the study will help nurses to offer you better care. I am looking for volunteers to join group discussions about hospital patients' understanding of health and health promotion.

If you have been involved earlier in the observation stage in relation to this study, you are also welcome to participate in focus group discussions. If you have been in hospital for at least a week, I am asking you to join a group of (6-12) patients. If you agree to take part in this project, your name will first be put in a list with other patients' names. Then, after two days, I will select randomly the names (e.g. every third person) for the group discussion. I will contact you in person later if you have been selected.

I expect that the discussion will last about 45 minutes to one hour. I will tape record the discussion, so that I can have an accurate record. If your name can be identified from your voice, it will be replaced by a number and thus no one will identify you. Refreshments will be provided during the discussions taking into account your health problem (e.g. Juice, fruits). I will contact you later to ensure that I have correctly

reported your views. Further information about where the discussion will be held will be given to you later.

Participation in this study is completely your choice. You can withdraw from the study at any time without giving a reason. Your joining in or not will not affect the care delivered to you. The results may be published at the end of the research.

If you would like to contact an independent person, who knows about the project but not involved in it, you are welcome, to contact Dr Samiha Jarah. Her contact details are given below. If you have understood this information sheet and any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

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Appendix 11 Information' sheet for surgical and medical ward supervisors



Queen Margaret University
EDINBURGH

I am Noordeen Shooqirat- research student from the Nursing School-Queen Margaret University in Edinburgh/ Scotland. As part of my PhD degree, I am undertaking a research project funded by Muttah University. The title of my project is "The role of Jordanian hospital nurses in promoting patients' health". The project aims to understand hospital nurses' roles in promoting patients' health. No study has been done in this area in Jordan and thus it is hoped that the study will offer valuable results that could guide the future development of nursing health promotion activities in hospitals.

Sometime ago I undertook some research with hospital nurses and patients. Following on from this, I am now interested in examining nursing health promotion from your perspective.

If you agree to take part in this research, you will be asked to participate in a 45 minute-1hour interview at a time and place convenient to you. The interview will be mainly focusing on your views about nurses' health promotion role in hospitals as well as factors that could affect such a role. The interview will be tape recorded for transcription and analysis purposes. Tape recordings later will be destroyed and only me and my supervision team will have access to them.

The study is entirely voluntary. There is no obligation to participate and you can quit any time without giving a reason. The data will be anonymised as much as possible, but you could be identifiable from tape recordings of your voice. In this case your name will be replaced with a number and it will not be possible for you to be

identified at any reporting of the data gathered. All the information will be kept confidentially for the purpose of this research. At the end of this study, a summary of key results will be given to you if requested. The results may be published at the end of this research.

If you would like to contact an independent person, who knows about the project but not involved in it, you are welcome, to contact Dr Samiha Jarah. Her contact details are given below. If you have read and understood this information sheet, any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

In anticipation, thank you very much for your help

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Appendix 12: Information sheet for the nursing educator



Queen Margaret University
EDINBURGH

I am Noordeen Shogirat- research student from the Nursing School-Queen Margaret University in Edinburgh/ Scotland. As part of my PhD degree, I am undertaking a research project funded by Muttah University. The title of my project is “The role of Jordanian hospital nurses in promoting patients’ health”. The project aims to understand hospital nurses’ role in promoting patients’ health. No study has been done in this area in Jordan and thus it is hoped that the study will offer valuable results that could guide the future development of nursing health promotion activities in hospitals.

I am interested in examining nurses’ roles in promoting patient’ health from your perspective as a nursing teacher . If you agree to take part in this study, you will be asked to participate in a 45minute-1hour interview at a time and place convenient to you. The interview will be mainly focusing on nurses’ curriculum and training with regard to health promotion. Also, the interview aims to identify potential factors that could affect the development of nurses’ health promotion role within the hospital setting. The interview will be tape recorded for transcription and analysis purposes. Tape recordings later will be destroyed and only me and my supervision team will have access to them.

The study is entirely voluntary. This means that there is no obligation to participate and you can quit any time without giving a reason. The data will be anonymised as much as possible, but you could be identifiable from tape recordings of your voice. In this case your name will be replaced with a number and it will not be possible for you to be identified at any reporting of the data gathered. All the information will be kept confidentially for the purpose of this research. At the end of this study, a

summary of key results will be given to you if requested. The results may be published at the end of this research.

If you would like to contact an independent person, who knows about the project but not involved in it, you are welcome, to contact Dr Samiha Jarah. Her contact details are given below. If you have read and understood this information sheet and any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

In anticipation, thank you very much for your help

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Appendix 13: The Consent Form



Queen Margaret University
EDINBURGH

The Project Title: “The role of Jordanian hospital nurses in promoting patients’ health”

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I agree to participate in this study.

Name of participant:

Signature of participant:

Signature of researcher:

Date:

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